

# **Shining a Light on Care in Direct Social Work Practice**

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**A dissertation submitted in fulfilment of the requirements for  
the degree of Doctor of Philosophy (Social Work)**

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# Abstract

This study critically examines how care operates as a concept and practice in direct social work practice. While ‘care’ has been positioned as a core value of the social work profession since its inception, the increasing influence of neo-liberal rationalities and evidence based practice have placed care on the periphery of social work practice. Social work scholars have promoted the incorporation of ethic of care theory into direct social work practice as a means of countering the effects of a context that is antithetical to caring practice. The research provides an original contribution to an understanding of care. I address the gap between abstract notions of an ethic of care and concrete ways of enacting care in direct social work practice, by capturing the lived experience of social workers and social work clients.

My qualitative research was guided by a grounded theory approach to answer the question: how does thinking about, doing and experiencing care in direct social work practice inform an ethic of care for the profession? Fifteen social workers and 15 social work clients from Tasmania were recruited through purposive and snowball sampling. They were interviewed using a semi-structured interview schedule. The interviews were analysed using constructivist grounded theory techniques.

Deep listening, non-judgment, a commitment to meeting needs, showing empathy and compassion, and just being there for clients in times of distress were some of the ways that social workers and clients said care was demonstrated in practice.

Additionally, clients indicated mutual trust was a vital component of care. Both social workers and clients shared inspiring accounts of caring practice, however, clients also frequently mentioned experiences of uncaring practice.

On the basis of these findings I suggest a practice theory of care that is reflective of Tronto’s (1993) five dimensions of care. Extending Tronto’s conceptualisation of care, I add that an ethic of care in direct social work practice involves perceiving care as a ‘virtue’, continual evaluation of caring practice, developing trusting relationships, and balancing a commitment to social justice with care. My theory of care culminates in ‘valuing the other’. The implications of these findings are discussed, alongside ideas for future research.

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# Chapter 1: Introduction

## Introduction to the Chapter

This introductory chapter provides an overview of how and why care in direct social work practice became the focus of my research. I argue that taken for granted notions of care require dismantling in order to understand how care is constructed in professional social work practice. I begin the chapter by explaining how I was initially drawn to researching the concept of care. I highlight the confusing and ambiguous use of the term ‘care’ in social work practice: I contend that until there is a coherent view of what the term means and how it is reflected in practice, it will remain difficult to build a framework for caring practice. This is followed by an outline of concerns (Gray 2010; Webb 2006; Meagher & Parton 2004; Bauman 2000) that the social work profession has become increasingly influenced and regulated by neoliberal ideologies and evidence-based practice, which has resulted in undermining care as a value in social work practice. I support suggestions that drawing on ethic of care theory may be a useful way of returning care to the centre of direct social work practice and countering the difficulties the current context poses to caring practice (Barnes 2012; Dybicz 2012; Gray 2010; Meagher & Parton 2004). While I note that academics have brought attention to valid concerns about the position of care in the professional context, I assert that there is a lack of empirical research on this topic. My study addresses this gap, exploring how care operates as a concept and practice in direct social work practice interventions.

I state the study’s focus, aim and the primary research question that guided the research. Given the contested nature of the concept of care, I explain the conceptualisation of care that I have used in this study, enabling me to present an argument for the focus and content of the research. This also provides a context for arguing my specific research question, that being: *How does thinking about, doing and experiencing care in direct social work practice inform an ethic of care for the profession?* The final section of the chapter presents an outline of the structure and content of the thesis.

## **Background to the Study**

In this background section of the chapter I explain my motivation for exploring the topic of care in direct social work practice and why it is an important, relevant and timely research topic.

### **What led to my exploration of care in social work practice?**

My own interest in care as it relates to social work practice was piqued about six years ago, during my first year of practice as a qualified social worker. I was working with a young woman who was experiencing depression for the first time. Jane (pseudonym) was articulate and intelligent. She had clear goals for her future, supportive family and friends, and no apparent systemic or structural issues seemed to be impacting her wellbeing. Nevertheless, she had been overtaken by a depression that was debilitating, robbing her life of joy and affecting her ability to study. I encouraged Jane to see her doctor as well as to organise some specialist mental health support, and I continued to see her on a regular basis while these interventions were happening. We spoke about how she was feeling and coping, and her hopes and dreams for the future. One particular day she spent most of our time together crying, explaining that she hated what was happening to her and while she understood that it would take time for her medication to work, she was afraid she would never return to her 'old self'. All I wanted to do was take her pain away and I felt useless that I could not do so. Later that day I spoke with my supervisor and explained that I felt that I was not helping Jane and that I felt incompetent. She replied, 'So what was it that you did do?' I said that I had just sat with her, allowed her to cry, listened and let her know that I would be there for her whenever she needed support. My supervisor made close eye contact and said, 'So, you think you are not helping? What you did was show her care. What you did was huge and very important. Never underestimate the value of that sort of support'. Those words have remained with me since that day and I began to realise that care is not often spoken about in social work theory or within organisations, and this did not make sense to me. Many social workers are initially attracted to the profession because they want to help others, because they want to make a difference in peoples' lives, because they are passionate about social justice issues, effecting change in the world and



ultimately, because they ‘care’. I began to think about why there was little mention of this concept in the social work literature and professional forums.

### **Why is this research needed?**

Since its inception social work has been regarded as a ‘caring’ profession, a profession that holds care as a fundamental core of its value base (Gray 2010; Parton 2003; Weick 2000; Freedberg 1993). It is doubtful that anyone would perceive ‘uncaring’ social work practice as anything other than the antithesis of what the profession stands for. Yet, care is an aspect of practice that has been taken for granted and is a concept that until very recently has not been discussed in the literature. It is difficult to determine what is even meant by the term ‘care’ in spite of its ubiquitous use across fields of social work practice (Clapton 2008; Fine 2007). Clapton (2008, pp. 583-574) makes the observation that Australian human service organisations are increasingly adding the suffix ‘care’ to their organisational name. Examples include: Uniting Care, Baptcare, CatholicCare, Anglicare, Masonic Care, and Ozcare. Clapton (2008) criticises this trend, arguing that it reveals a tokenistic and superficial use of the term. She argues that the language of care needs to be meaningfully embedded within organisational policy and practice, with consideration of what the concept really means. Fine (2007) shares a similar sentiment, maintaining that care is a word that is too often bandied around as a marketable tool that ‘invokes a warm feeling of approval in most people’, while not holding any significant meaning in day-to-day organisational activities. Several writers (Phillips 2007; Webb 2006; McBeath & Webb 1997) argue that the use of language around care in the public world is all too often used as a device that strategically controls individuals and legitimates the use of professional power. According to McBeath and Webb (1997, p. 48) this is a strategy that is more concerned with control than any real sense of compassion and understanding towards the other. Until there is some consensus in regard to what is meant by ‘caring’ social work practice, the term will continue to be used in a vague and meaningless manner. A comprehensive, coherent understanding of what it means to care in social work practice remains elusive and like clouds in the sky; ideas of what constitutes care constantly shift and change, and at times disappear altogether.

It is only since the early 2000s that social work scholars (Dybicz 2012; Gray 2010; Gregory 2010; Holland 2010; Banks 2006; Lloyd 2006; Webb 2006; Hugman 2005; Meagher & Parton 2004; Parton 2003; Clifford 2002) have begun to place an emphasis on the importance of ‘care’ as a discreet concept in the profession. This interest has largely been in response to the challenges posed by the neoliberal political context that the social work profession is now located within. This context is informed by individualistic values, including freedom of choice, market security, independence, self-responsibility and risk aversion. It is a context that holds evidence-based practice as the ‘gold standard’, in spite of the fact that much of the work social workers do cannot be measured in concrete terms (Dybicz 2012; Webb 2006; Hugman 2005; Parton 2003). It is a context in which rational-technical models of social work practice are considered superior to relationship based approaches (Webb 2006; Hugman 2005; Parton 2003). Ultimately, it is a context that places little value on, and leaves little room for care.

In an attempt to address the precarious situation of care in the professional social work context, discussions by social work researchers have mainly focused on the potential contribution of ethic of care theorists (Sevenhuijsen 1998; Tronto 1993; Noddings 1984; Gilligan 1982). Ethic of care theory asserts that care occurs through relationship with others and ethical decisions are based on individual contexts rather than driven purely by universal rules and principles (Tronto 1993; Noddings 1984; Gilligan 1982). The focus on relationship ensures that care is not something that is forced upon or ‘done to’ the client. Instead, an ethic of care requires ‘working with’ the client and a commitment to promoting the autonomy of the client whenever possible. I contend that in spite of the presence of these ideas in the literature, there has been a lack of empirical research that demonstrates how ethic of care theory may or may not be appropriate and applicable to the embodied aspects of direct social work practice. As Featherstone (2010), Banks (2008) and Parton (2003) argue, the social work profession needs to establish a detailed approach for applying an ethic of care if these ideas are to be taken seriously.

The aim of this study was to respond to this call for practical suggestions, to bridge the gap between theory and practice and analyse how social workers’ and social work clients’ views and experiences of care can inform an ethic of care for social

work direct practice. This led to me ask the question: *How does thinking about, doing and experiencing care in direct social work practice inform an ethic of care for the profession?* My assumption and observation was that in spite of an ethic of care not yet being formalised in social work practice, social workers do care and clients have expectations and experiences of caring social work interactions. What an ethic of care in direct social work practice might look like remained uncertain when I embarked on this research. As I explain in the next section of this chapter, locating care in a social constructionist perspective assisted me to identify the unique ways that participants considered and enacted care. It enabled me to move beyond abstract, generalised notions of care to concrete, specific ideas that when combined helped inform an overall picture that can inform an ethic of care for direct social work practice.

## **Conceptualising care as a social construct in this research**

Care is a broad concept that relates to many aspects of life both in the private and public domains. Parents care for their children and family members, and friends care for one another. People care about their environment, pets, careers, hobbies, material possessions, bodies, and their mental and emotional wellbeing. Care can be described in terms of labour and in terms of emotional support. The online Oxford Dictionary (2014) provides multiple definitions of care, ranging from ‘the provision of what is necessary for the health, welfare, maintenance and protection of someone or something’ to ‘avoiding damage or risk’ to ‘feel affection or liking’. With so many different understandings of care, it is not surprising that confusion abounds when the word is used in professional settings without in-depth discussion about what the term actually means.

For the purpose of this research, I honed the focus to consider understandings of care in relation to the professional domain and more specifically direct social work practice – that is, I focused on the care that occurs through relationships between social workers and their clients. Direct practice refers to interpersonal social work

interactions at the micro level of social work practice and includes direct work with individuals, groups and families (Corcoran 2012, p. 5). It also requires an understanding of how social systems and structures impact on and interrelate with individual problems (Hepworth, Rooney, Dewberry Rooney & Strom-Gottfried 2013).

My research was based on the view that care is a social construct. Social constructionism is guided by a relativist stance that contends that meaning about reality is subjective and partial (Crotty 1998; Berger & Luckman 1991). The social constructionist view does not deny the reality of a material world, but contends that the world can only be given meaning through human interpretation (Crotty 1998; Berger & Luckman 1991). Social constructionists make no definitive ontological claims; instead they focus on the social construction of knowledge (Andrews 2012; Berger & Luckman 1991). Multiple interpretations about the 'nature of reality' are therefore possible and arrived at in relationship with others, with shared systems of meanings derived through culture, discourse and language (Andrews 2012; Smith, Todd & Waldman 2009; Crotty 1998; Berger & Luckman 1991). In the case of 'care', it is not something that can be observed in a material way. Instead, care is simply a label that has been given to certain ways that people express themselves within relationships with one another (Bevis 1988). Care is therefore constructed through relationship and the way that it is expressed and enacted varies between individuals and cultures (Bevis 1998). Meanings of care also change over time as world views, societal laws and social norms evolve through reconstruction (Crotty 1998). It is this subjective and deeply contextualised understanding that I have explored in this study in order to gain an understanding of the ways in which social workers think about and do care, and how clients experience care. Having said this, my study did not focus on specific cultural understandings of care, a limitation of the study that I have acknowledged in the final chapter of this thesis.

Even within the helping professions, care is a contested concept. It is a concept that can be understood as personal, public, gendered, political and/or moral. Therefore, it is apparent that care has no objective reality and only comes into being through subjective experience and individual contexts (Bevis 1998; Crotty 1998; Tronto 1993). If I had taken an objectivist stance in my research, based on a specific notion

or theory of care, it would not have been possible to capture the nuanced, varied ways that social workers and social work clients perceive and enact care. I chose to approach this study from a feminist social constructionist perspective. While early ethic of care theorists viewed care and gender differences through an essentialist lens (Noddings 1984; Gilligan 1982) more recent arguments have centred on the constructionist aspects of care and gender, and considered how care intersects with many other factors, such as age, class, sexual orientation and ethnicity (Tronto 2013; Phillips 2007; Parton 2003; Sevenhuijsen 2003). Parton (2003) argues that it is important not to essentialise gender differences in such a way that necessarily creates unhelpful binaries. He argues that care is central to everyone and although gender differences cannot be dismissed, it is useful to consider how people in general (regardless of gender) construct notions of care in order to be able to find a way to return care to the centre of social work practice.

Viewing the topic through a feminist social constructionist lens enabled me to dismantle taken-for-granted conceptions of care and to study care broadly, enabling consideration of how an ethic of care could translate into direct social work practice. I chose to take an approach that allowed for ideas to emerge that show how an ethic of care fits into the unique context that direct social work practice is situated in. A feminist social constructionist stance enabled me to explore the embodied experiences of care from the perspectives of social workers and social work clients, remaining open to different ways of thinking about how care is conceptualised, enacted and experienced in social work practice.

## **The Structure and Content of the Thesis**

The structure and content of this thesis is as follows. The first two chapters are concerned with the exploration of the literature on care. Chapter 2 presents a critical overview of definitions and theories of care, including contributions from nursing scholars, ethic of care theorists and other moral theories that link to care and are relevant for consideration in social work practice. Chapter 3 presents the literature relating specifically to care in social work practice. The chapter includes a brief history of care in social work, discussions pertaining to the incorporation of an ethic

of care in the professional social work context, and the existing empirical research that relates to care in social work practice. I conclude this chapter with a rationale for conducting further research on care, arguing that research to date is scant and that an in-depth investigation of care from the perspectives of both social workers and social work clients, across a wide range of fields of social work practice is required in order to inform how an ethic of care may be applied to direct social work practice.

The methodology and methods of my research which I have outlined in this introductory chapter are discussed further in Chapter 4. I explain in more depth the purpose for conducting the research from a social constructionist paradigm. I argue that a qualitative, constructivist grounded theory design was the most appropriate means of exploring ways that care is constructed in social work practice. I explain how ethic of care theory informed the research process. The methods of data collection and analysis are presented, along with ethical considerations.

Chapters 5, 6 and 7 comprise the data chapters of the thesis, with chapters 5 and 6 presenting the findings from the interviews with social workers and Chapter 7 presenting the findings from the interviews with clients. Chapter 5 presents the way that social workers conceptualise care in their practice, including the meaning they give to care, the features of caring practice and the relevance of care to direct social work practice. Chapter 6 presents ways in which social workers enact care in their practice, providing concrete examples from participants' interactions with their clients. This chapter demonstrates the difficulties that these social workers faced when trying to uphold caring values in what they describe as a neoliberal context that often does not support such values. At the same time, a narrative of resistance emerged, showing that social workers managed to continue to care in spite of the constraints and value conflicts they faced.

In Chapter 7 the views and experiences of social work clients are presented. The client narrative is raw, simple and powerful, depicting care as essential to a positive social work experience and a lack of care as demeaning and damaging. In contrast to the positive picture of care painted by social workers in Chapters 5 and 6, client participants revealed that 'uncaring' social work experiences were all too frequent.

Chapter 7 highlights the importance of giving a voice to the key stakeholders of social work services, the clients themselves.

Chapters 8 and 9 are the discussion and concluding chapters of my thesis respectively. Chapter 8 brings together the results from the three data chapters. I argue that this research indicates that social workers demonstrated care by ‘caring about’ and ‘caring for’ their clients. I contend that social workers displayed courage and a commitment to taking responsibility for caring practice by challenging and resisting organisational rules and policies that compromised their moral commitment to care. I identify that social workers also recognised a need to attend to professional boundaries and their own self-care if they were to maintain care for others. Furthermore, caring for clients did not preclude social workers’ responsibility to consider social justice issues.

I contend that the client findings largely support social workers’ depictions of what constitutes caring practice; however, emphasis is placed on the importance of building trust in caring relationships as well as a sense of feeling valued by social workers as a sign of care. The frequent accounts of ‘uncaring’ social work practice in the narratives of client participants, and the impact these experiences had on participants were a significant finding that raised concerns that not all direct social work practice leads to positive experiences and positive change for clients.

I conclude in Chapter 9 that the findings from this research support arguments for the incorporation of an ethic of care into professional direct social work practice. Drawing upon participants’ perspectives and practice examples and in particular the concerns expressed by the clients who participated in this research, I propose a practice theory for direct social work practice and make recommendations for social work education and training. In view of the limitations of the study, I provide suggestions for future social work research.

## **Concluding Comments to the Chapter**

In this introductory chapter to my thesis I have identified the theoretical and methodological foundations that have underpinned my research on care in direct social work practice. I have highlighted that it is important to research how social workers and social work clients think about, do and experience care, when the professional context seems hostile to social work values. I have also stated the aims of the research and the research question. I develop the argument for the importance of this research in the next two chapters as I present the literature on theories of care and research to date.



# **Chapter 2: Theorising the Nature and Operations of Care**

## **Introduction**

In this chapter I present a review of literature that focuses on how the concept of care, as it relates to ethical concerns in the public world, has been conceptualised and theorised. While ideas vary, commonalities are evident throughout this literature, which assist in creating a general understanding of what it might mean to care and the role of care in the public and political world that helping professions are situated in. I provide and discuss a variety of definitions of care as it relates to the helping professions, highlighting both the way the use of the word ‘care’ is taken for granted and the socially constructed nature of the concept. Conceptualisations of care within the nursing profession are explored and I consider how these meanings of care offer possible insights for the profession of social work. Next, the literature on an ‘ethic of care’ in which care is theorised as a moral stance that contrasts with traditional ethics of justice is reviewed. Both perspectives are explained and critically analysed. The terms ‘ethics’ and ‘morality’ are often used interchangeably in the literature, as will be the case in this review. I conclude this chapter by presenting Bauman’s moral theory and theories of virtue ethics. I argue that both of these perspectives contain components that can be linked to and complement ethic of care theory.

## **Theorising Care**

In recent times, theorising the nature and practice of care in the public world has become increasingly prevalent within the academic literature. Bradshaw (1996, p. 1) argues that this preoccupation with care in the ‘caring professions’ is due to a loss of the tradition of caring over time. Bradshaw (1996, p. 1) contends that in the early days of professions such as nursing and social work, care did not need to be defined or theorised, stating that, ‘Care was no mere ethical discourse or idea; it was

incarnated, lived out, practical action'. In regard to social work practice, it is argued that a tradition of care has been buried beneath concerns for ways of working that follow scientific evidence based knowledge and adhere to current political and economic agendas (Dybicz 2012; Gray 2010; Banks 2006; Webb 2006 Hugman 2005; Parton 2003). According to Banks (2006, p. 15) such agendas have led to focusing on equity at the expense of empathy, aiming for good economic outcomes at the expense of attending to the needs of the most impoverished, and treating clients as cases or numbers rather than as individuals. These views indicate that it is time to revisit the notion of care, regain an understanding of what care is about and how it can assist social work to maintain its core values (Gray 2010; Webb 2006; Parton 2003). To begin this process, I examine definitions of care in an attempt to clarify the term as it relates to the caring professions.

## **Defining care**

As mentioned in Chapter 1, 'care' is a familiar term in the helping professions, yet there appears to be much confusion about what is meant by the concept. At first glance 'care' and 'caring' are often seen as common-sense, taken for granted notions, and render care a difficult concept to define (Rauner 2000; Hugman, Peelow & Soothill 1997). As Rauner (2000, p. 4) states:

Like its counterparts love and hope, care is all too often used as a sugar-coated word, encountered on a greeting card. After so much overexposure, the very concept of caring might seem trite or meaningless.

Given the focus of this research I have reviewed definitions of care that relate to the helping professions and social welfare. Such exploration reveals myriad ways of defining care, demonstrating the constructed nature of the concept, as well as an apparent lack of any real consensus of its meaning. McBeath and Webb (1997, p. 45) point out that the word 'care' appears throughout the academic literature without explanation of what it actually means, and with authors failing to discuss the concept theoretically or in conceptual terms. Nevertheless, there is a small but growing body of literature in which scholars focus on the conceptualisation and value of care in the public world, as well as more specifically in the helping professions (Payne 2011; Fine 2007; Phillips 2007; Rauner 2000; Bevis 1998; Montgomery 1993; Tronto 1993; Mayeroff 1971). Writers have made a distinction between 'caring about'

which involves an emotional commitment towards another and ‘caring for’, which refers to the tasks required to be carried out in order to sustain or improve another’s wellbeing (Fine 2007; Tronto 1993; Graham 1983). Hugman, Peelo and Soothill (1997, p. 5) point out that people who care for others may not feel an emotional commitment to care. Bevis (1988, p. 58) supports this view arguing that a duty to care for others may arise from caring feelings, but caring about another person does not arise from duty. She claims that genuine care requires an emotional response, arguing that without it caring actions become ‘warped, non-functional or stagnant’ (Bevis 1988, p. 51). Bevis (1998, p. 52) defines care as:

A feeling of dedication to another to the extent that it motivates and energizes action to influencing life constructively and positively by increasing intimacy and mutual self-actualization.

A definition of care provided by Tronto (1993, p. 102) captures ideas of both ‘caring about’ and ‘caring for’:

Care is a reaching out to something other than self; it is neither self-referring or self-absorbing...and secondly requires some form of action.

According to McBeath and Webb (1997, p. 46), genuine care only occurs when the needs of the other, as perceived by them are recognised and attended to. They explain:

Care is doing tasks in a way mindful of the objective and subjective reflected-upon interests of the person for whom the tasks are done (McBeath & Webb 1997, p. 46).

Several authors (Phillips 2007; Hugman, Peelo & Soothill 1997; Tronto 1993; Bevis 1988) contend that one of the reasons why definitions of care vary widely is because there are cultural differences in the way that care is perceived. A broad and commonly quoted definition of care provided by Fisher and Tronto (1990) allows for cultural variations. They define care as:

A species activity that includes everything that we do to maintain, continue and repair our world so that we can live in it as well as possible. That world includes our bodies, our selves and our environment, all of which we seek to interweave in a complex, life-sustaining web (Fisher & Tronto 1990, p. 40).

This definition has been criticised for being too broad (Held 2006; Groenhout 2004), as care could be attributed to almost any activity in life. Tronto (2013) has recently defended such criticisms, claiming that the broad nature of the definition leaves open

possibilities for alternative conceptualisations of care to be considered along with specific definitions of care within particular contexts. This definition extends beyond the private realm of care, incorporating care in the public domain. Fine (2007) sums up the dilemma that is faced when attempting to define care, while at the same time holding onto the view that attempts to understand this concept are deeply important. Fine (2007, p. 2) argues that:

A single definition of care remains elusive, in part because it refers at once to an ideal set of values and series of concrete practice. The outcomes of the struggle to define and claim care matter, but they are not pre-ordained. The debate, for this reason, is as urgent as it is profound.

Until a tighter consensus is reached about the meaning of care in the public world, it remains difficult to discuss the practise of care and to determine its presence or absence in helping professions. While social work has offered little in regards to understanding the concept of care, nursing scholars have conducted an impressive amount of research on this topic, providing valuable insights for direct social work practice.

### *The nursing profession's contribution to understanding care*

Scholars from the nursing profession made a significant contribution to the body of work on care during the 1980s and early 1990s (Montgomery 1993; Morrison 1991; Morrison & Burnard 1991; Watson 1985; Larson 1984; Leininger 1981) and there are implications for social work in their work. A heavy influence on many of these authors was philosopher Milton Mayeroff's seminal work, 'On Caring' (1971). Mayeroff's (1971, p. 2) main premise for caring for another person is helping the other to grow, while at the same time holding a deep regard for the other and his or her particular needs. He contends that caring not only assists in the growth of the one being cared for/about, but also the one doing the caring. He claims that caring fulfils the primary purpose of human life (Mayeroff, 1971, p. 2). Mayeroff (1971, p. 2) explains:

Through caring for certain others, by serving them through caring, a man [sic.] leads the meaning of his own life. In the sense in which man [sic.] can ever be said to be at home in the world, he [sic.] is at home, not through dominating, or explaining, or appreciating, but through caring and being cared for.

Mayeroff (1971, p. 7) proposes that a caring relationship requires eight elements. These are: knowing, alternating rhythms, patience, honesty, trust, humility, hope and courage. ‘Knowing’ refers to the gaining of knowledge of the other person and their needs and remaining aware of one’s own power and limitations. Mayeroff (1971, p. 8), describes ‘alternating rhythms’ as the continual modification of ways of reacting to one another, dependent on the situation, mood and responses given. ‘Patience’ requires taking time and being tolerant and appreciative of differences between self and others. He defines honesty as avoiding deceit and lies, while being open about one’s own feelings and views. According to Mayeroff (1971, p. 9), developing a mutual sense of ‘trust’ is an important constituent of a caring relationship. ‘Humility’ involves an awareness of the privilege of being trusted. Mayeroff (1971, p. 9) claims that it is also about not placing too much value on one’s own knowledge and skills and being open to learning from the other person. ‘Hope’ refers to believing in the possibility for positive change and overcoming adversity, and ‘courage’ is described as being prepared to take risks due to outcomes rarely being certain.

Montgomery (1993, p. 13), another key author on care in nursing, asserts that caring involves a process that happens over time and therefore takes work. She contends that little things such as a gentle touch, listening, a mere physical presence, and attending to physical comfort (the right chair, the offer of a drink) assist with creating a connection and a sense of care. This sense of presence as an expression of care has also become a topic of interest for nursing scholars since the 1980s (Covington 2005; Engebretson 2004; Snyder, Brandt & Tseng 2000; Eriksson 1992; Watson 1985; Leininger 1981). Presence has been described as offering unconditional support by simply sitting with a person and accepting whatever the situation may bring, whether that be silence, tears, expressions of anger or the desire to talk (Engebretson 2004; Snyder et al. 2000).

Along with these ways of conceptualising care in the nursing profession, a considerable body of empirical research has also been conducted that has implications for social work practice. Morrison (1991) conducted one of the few qualitative studies to date on nurses’ perceptions of care in their work, and established that the descriptions of the ‘caring nurse’ can be divided into seven

categories. These were: personal qualities, clinical work style, interpersonal approach, level of motivation, concern for others, use of time, and attitudes. Personal qualities included kindness, genuineness, patience, appropriate humour, honesty, compassion, flexibility, a calm disposition, tolerance, and understanding. A caring clinical work style involved treating people as individuals, attempting to identify and meet needs, being organised, reliable and skilful. The study found that a caring interpersonal approach was demonstrated through empathy, being approachable, deep listening skills, sensitivity, friendliness and a skilful communication style. A high level of motivation towards caring practice was displayed through genuine interest and commitment towards the other. A preparedness to give time to people and a down-to earth professional attitude were described as strong indicators of care (Morrison 1991).

Adamski, Parsons and Hooper (2009) analysed nursing students' perceptions of care. The students believed care to be of great importance in nursing. A gentle touch on the arm, making eye contact, listening and building trust were believed to help patients know the nurses cared. Montgomery (1993, p. 99) identified what she termed 'the transformative effects of caring' from the stories of nurses she spoke with. For example, one participant described how a four year old child with cancer had become withdrawn and would not speak to anyone. The nurse rocked him for an hour and a half and after that he started talking again and seemed to be much more at peace with his situation and consequently began responding to treatment (Montgomery 1993, p. 103). The transformative effect was also experienced by the nurses as is suggested by comments such as, 'It feels good to care; it is self-reinforcing and energising' (Montgomery 1993, p. 99). Conversely, participants did recognise that there are emotional risks involved with caring and that there are times when it may be necessary to disengage a little, take some time out or to try something new (Montgomery 1993, p. 106).

Engebretson (2004) presented a case-study that illustrates the value of a 'caring presence'. While supervising a student nurse (Brenda), a situation arose in which a female patient (Mrs Q) had just been informed that her new-born child had only hours to live. When the student was asked to 'be with' the woman throughout this

time she expressed concern that she did not know how to do this. Engebretson (2004, p. 237) explained her response as follows:

I was at a loss for words, and all I could tell her was, 'You need to be with her'. I added that this was a time when 'being with' might be in silence and it was ok not to talk. I finally replied, 'Just be with her throughout the shift and I will check on you frequently. Stay with her and focus on her experience'.

This intervention was described by Engebretson (2004, p. 239) as a powerful example of care, whereby a strong connection began to form between Brenda and Mrs Q in spite of very few words being exchanged, or any specific actions being taken other than an occasional touch on the arm or shoulder as an offer of support.

While these studies discuss views of caring from the perspective of professionals, the main limitation of this work is that it does not consider the direct view of the client/patient. It has been argued that caring responses are only of significant value when the sense of care is felt by the recipient (Montgomery 1993; Mayer 1987; Larson 1984; Mayeroff 1971). Several studies have paid attention to patients' views of care. Larson (1984) surveyed 57 cancer patients who ranked the most important aspects of nursing care. Larson (1984, p. 47) used an assessment instrument titled the CARE-Q, which she devised from professional nurses perspectives on caring behaviours. While nurses had identified listening and talking as the most important aspects of caring behaviour, the patients in this study reported 'being accessible' and 'monitoring and following through' as most important (Larson 1984, p. 49). The skills of listening and talking only seemed to become more important to the patients once their basic 'getting better' needs were met (Larson 1984, p. 50). While the instrument used in this study potentially placed limits on the participants' responses, the study did show that the nurses' assumptions about what matters most to patients in regards to caring behaviours may not always be correct.

The patient's perspective on care was captured in Riemen's (1986) study. His phenomenological approach to understanding patients' views of care provided rich descriptions of uncaring practice. Riemen (1986) heard disturbing stories from patients who felt that they were treated as an object rather than a person. They reported that they did not feel valued and believed that many nurses came across as cold, impatient and rude. When asked to describe both a caring and uncaring

interaction with a nurse, patients consistently described the uncaring interaction first, often years after it had been experienced, indicating the strong impact it had on them (Riemen 1986, p. 34).

### *Contributions to discussions of care from other helping professions*

While the nursing discipline has been by far the biggest contributor to discussions of care in the helping professions, there is a small body of literature that contributes to these discussion from the disciplines of psychology and education. Gilligan (1982) presented a challenge to Kohlberg's psychological theory of moral reasoning based on conventional Kantian ethics, arguing that an 'ethic of care' should inform theory and practice. Yet, while her theory has been widely used in the discipline of nursing and education, and gained some traction early on in her own discipline of psychology, it has had minimal influence on psychological moral theory in recent years (Govrin 2014). Neither has there been any discussion of how an ethic of care can be applied to therapeutic work in psychology. Govrin (2014) partly attributes this diminished status to how Gilligan's theory places too much emphasis on the psychology of women and the differences between the moral reasoning of men and women, with not enough emphasis on what constitutes 'right' moral judgment in general.

Over the past two decades, moral psychologists (Haidt 2012; Bargh & Chartrand 1999) claimed that moral intuition, emotions and affect are the basis for moral judgments, and that reasoning plays a minor role. They argue that Kohlberg's longstanding theory based on rational thinking about moral issues has become out-dated. Govrin (2014, p. 3) argues that 'The debate between Kohlberg and Gilligan was so central to the identity of care ethics that when Kohlberg's theory began to lose its relevance the same happened to ethics of care'. In spite of this, Govrin (2014) contends that an ethic of care should not be discounted as an important theory in moral psychology, particularly in terms of informing infant research and attachment theory.

In contrast, Noddings' (2005, 1992) version of ethic of care theory has significantly influenced conversations about care in the teaching profession, (Garza, Alejandro, Blythe & Fite 2013; Alder 2002; Agne 1999; Collinson, Killeavy & Stephenson



1999) that link student success and a teacher's ability to demonstrate genuine care. Yet, the teaching professions' current education programs and professional development programs continue to neglect the impact of an ethic of care on educational processes and outcomes (Owens & Ennis 2005).

Thus far the literature presented has included discussion and research on care as a concept, both in terms of meaning and application. I have briefly mentioned 'ethic of care theory' above in the section titled, 'Contributions to discussions of care from other disciplines', where I introduce how care is located in the ethical domain, and where care is perceived to be of moral significance. I explain this theory in depth in the next section.

### **Ethic of care theory**

It is ethic of care theory that has mainly influenced a resurgence of interest in care as it pertains to the social work profession. Therefore, it is important to outline this theory and explain what ethic of care theorists have to say about care as an ethical stance. The ethic of care was first proposed as a viable moral theory in the 1980s by feminist theorists Gilligan (1982) and Noddings (1984), who questioned whether something was missing in the traditional Kantian approach to morality. According to ethic of care theorists it is always through relationship that care occurs (Held 2006; Gilligan 2002, 1982; Noddings 1995, 1984; Tronto 1993). Noddings' (1984) account places great importance on listening when engaging in a caring relationship and refers to this type of listening as 'engrossment' which requires the carer to put aside his or her own biases and judgments and to attempt to understand the other's point of view, emotions and particular circumstance. According to Noddings (1984) understanding another person entails positioning oneself in a place of care, love, empathy, compassion and emotional sensitivity. She argues that understanding requires respecting the unique experience of the other rather than assuming that it is the same as if the carer were in the same situation. Of equal importance in Noddings' (1995, p. 26) view is that the carer takes care of themselves and receives care and support from others, as without self-care it is difficult to maintain care for others. Both Gilligan (1982) and Noddings (1984) view care as necessarily moving beyond concern and connection with the cared-for to taking action of some kind.

Tronto (1993) suggests that following an ethic of care comprises four phases and five ethical dimensions. The four phases consist of, caring about, taking care of, care-giving and care-receiving (Tronto 1993, pp.105-107). Caring about involves the recognition of suffering or need and making an assessment of how needs may be met. 'Taking care of' involves recognition of actions required to meet caring needs. 'Care-giving' is carrying out those actions, and 'care-receiving' involves recognition of responses to care. Tronto claims that observing and seeking responses to care is important as it provides a way of evaluating whether caring needs have been met.

Tronto's (1993, pp. 127-137) five ethical dimensions of an ethic of care consist of attentiveness, responsibility, competence, responsiveness and integrity.

'Attentiveness' requires the carer to suspend one's own goals and concerns in order to recognise and be attentive to others (Tronto 1993, p. 127). Tronto (1993, p. 132) distinguishes between 'responsibility' and obligation, arguing that obligation arises from a sense of duty, whereas responsibility comes from an inclination to do 'the right thing'. From a perspective of responsibility care is viewed as an end in itself, rather than simply as a means to achieve certain outcomes (Tronto, 1993, p. 133). 'Competence' involves drawing on knowledge, skills and abilities to meet caring needs whenever possible (Tronto, 1993, p. 133). 'Responsiveness' necessitates considering the position of the other and remaining aware of the power held by the carer and possibilities for abuse of that power (Tronto 1993, p. 136). Finally, integrity demands that the four phases of care and the first four dimensions of an ethic of care are integrated into a complete whole (Tronto 1993, pp. 136-137).

A special issue of the *Ethics and Social Welfare* journal, published in 2010, includes articles from authors that highlight the relevance of considering care as a concept of value in political and welfare contexts (Held 2010; Lloyd 2010; Robinson 2010; Tronto 2010). In this issue, Robinson (2010) challenges current neoliberal approaches that dominate international political theory. She contends that replacing a focus on individualism with an international political theory of care that considers relationality, interdependence and responsibility to others will better address the needs of vulnerable citizens. Tronto (2010) argues a similar point, suggesting key features of an ethic of care be applied in institutional contexts. These features

include an awareness of the purpose of care, recognition of power relations, and the need for tailoring care to meet individual needs.

Lloyd (2010) links the political context with practice implications of caring. She uses the example of policies aimed at ‘caring’ for the aging population, arguing that they fail to take into account the importance of interdependence, relationships and responsibilities towards addressing individual circumstances. Finally, Held (2010) considers how broadening caring relationships beyond family and friendship could supplement and sometimes replace the need for justice approaches when dealing with family violence and terrorism. The frequently discussed distinction between an ethic of care and an ethic of justice is presented next.

### *Contrasting an ethic of care with an ethic of justice*

The ethic of care contrasts with the more traditional Kantian ethic of justice which has been the most influential moral theory since the time of the Enlightenment. Kant’s ([1785] 1964, p. 67) approach viewed ethical principles as abstract and universal, applying equally and impartially to everyone in the same situation. Kant proposed an ethical theory in which everyone is their own moral agent and should be respected as such. Certain principles should be followed, not in order to achieve particular means or to serve self-interest, but as a moral end in itself ([1785] 1964, p. 91). It is from Kantian ethics that formalised codes of ethics have been developed which along with rational scientific principles are a defining feature of most professions (Hugman 2005, p.6). The valuable contribution of Kantian ethics cannot be overlooked as it resulted in an enhanced humanitarian concern, an acknowledgment of the rights and needs of the lower classes and the recognition of slavery as a moral wrong (Tronto 1993, p. 58).

The ethic of justice has been criticised for failing to take into account the relational ontology of human beings – that individuals exist in relation to others, and that care and responsibility are a part of human interaction (Sevenhuijsen 1998; Tronto 1993; Gilligan 1987). Hankivsky (2004, p. 25) maintains that care is a necessary component of all peoples’ lives. She argues that while requirements may change depending on circumstances, age and health status, care remains a constant requirement to some degree or another. Universal perspectives do not sufficiently fit

a society that is more plural and fragmented than ever before (Bauman & Tester 2001; Bauman 1995, 1993). This argument also supports Kroeger-Mappes' (1994) strong stance on the value of care. Kroeger-Mappes (1994, p. 115) contends that 'solely following an ethic of rights would amount to the physical, psychological and emotional neglect of virtually everyone'.

As argued by Tronto (1993), an ethic of care is based on relationships, whereas an ethic of justice is based on abstract principles and rules. An ethic of care is founded on the belief that people are interdependent, whereas an ethic of justice promotes independence and autonomy. An ethic of care focuses on emotions and an ethic of justice focuses on rights. An ethic of care is associated with femininity, whereas an ethic of justice is associated with masculinity. An ethic of care is contextual and concrete, tailored to each individual, dependent on unique problems and circumstances that are only understood through relationship. An ethic of justice is abstract, and problems are categorised and approached according to broad, universal principles. Finally, an ethic of care is guided by a sense of responsibility, whereas an ethic of justice is guided by a sense of duty (Tronto 1993).

Table 1 summarises the key differences between an ethic of care and an ethic of justice approach as argued by Tronto (1993).

**Table 1: Key differences between an ethic of care and an ethic of justice**

<b>Ethic of Care</b>	<b>Ethic of Justice</b>
Relationships	Abstract principles and rules
Interdependence	Autonomy
Emotions	Rights
Feminine	Masculine
Contextual approach	Abstract approach
Responsibility	Duty

Several theorists contend that care and justice are logically compatible and indispensable to one another (Held 2006; Heckman 1999; Jagger 1995; Tronto

1993). Tronto (1993) believes that an ethic of care and an ethic of justice cannot be separated in the real world as the two moral philosophies are inextricably intertwined. Gilligan (2002, p. 683) echoes this view, drawing attention to the fact that everyone is vulnerable to both oppression and abandonment. As Gilligan (2002, p. 684) explains, oppression results in a moral command not to act unfairly toward others and abandonment, a moral command not to turn away from someone in need.

### *Gender and an ethic of care*

The first wave of ethic of care theorists promoted the idea that caring comes more naturally to women than men (Noddings 1985, 1984; Gilligan 1982). Gilligan (1982) found that when she spoke to women a different moral ‘voice’ was apparent to that of most men. When speaking about experiences of moral conflict and choice she describes the way in which women commonly define moral problems in terms of relationship to others rather than by a set of abstract universal rules and principles. Noddings (1984) believes care to be an innate female capacity that is linked to childbearing and nurturing. She argues that women are equally as rational about their moral decision making as men. Reasons often ‘point to feelings, needs, situations, conditions, and sense of personal ideal’ rather than universal principles to guide caring actions (Noddings 1995, p. 23).

While Gilligan views women as the ‘caring’ gender, she argues that differences between men and women are due to the way in which they are socialised to perform caring roles in society (1982, p. 4). Gilligan (1982) contends that it is not that women are less moral than their male counterparts, but they have a tendency to view morality from a different perspective. The different perspectives can be likened to the way in which people perceive ambiguous drawings in Gestalt psychology experiments (Gilligan 2002, p. 683). A picture which can be seen as either a young woman or an old woman is believed to be primarily seen as one or the other depending on expectations and past experience. Gilligan (2002, p. 683) argues that men have been socialised to perceive morality from a justice perspective whereas women have been socialised to perceive morality from a relational perspective. Like the ambiguous picture it is possible to shift the focus from one perspective to another, however, one perspective tends to dominate. While all human relationships can be defined both in terms of equality and attachment, and everyone is vulnerable

to both oppression and abandonment, it is the emphasis that men and women give to these interdependent concepts that determines which one they focus on (Gilligan 2002, p. 683).

Tronto diverts from the essentialist stance one step further disputing the idea that women care more than men. She argues that while Gilligan's work is important for highlighting a different perspective on morality, the idea that women have a different 'moral voice' to men is not conclusive. Tronto (1993, pp. 82-84) points to several studies that suggest that an ethic of care is equally evident in men as it is in women and that the reverse is also true in that women also display an ethic of justice. She argues that if differences lie anywhere it is more likely to be in regards to class and race than gender. African-Americans, for example, adopt a view of the self that stresses a sense of co-operation, interdependence and collective responsibility, all of which are more in line with an ethic of care than an ethic of justice (Tronto 1993, p. 84). This is echoed in Graham's (2002) account of an African-centred paradigm for social work that emphasises values relating to the importance of interpersonal relationships, a holistic view of the interconnectedness of all things and the collective nature of identity. Tronto (2013, pp. 68-70) claims that western men do care, although often the care that men provide is less intimate than that of women, and it is based more on protection, providing financial security and practical forms of care. Tronto (2013) argues that this is still 'care', nevertheless, and it is often motivated by a desire to demonstrate love. The main issue according to Tronto (2013, p. 69) is that generally men do not see themselves as particularly good at caring; they hold onto masculine ideologies that suggest 'tough guys don't care', even when their emotions and actions often contradict this idea. As a result, this renders it difficult for care to be taken seriously in a male dominated public world that relates more to ideas of justice than to care (Tronto 2013, p. 70).

### *Trust as another dimension of an ethic of care*

While trust is discussed as an element of caring relationships in the nursing literature (Adamski, Parsons & Hooper 2009; Montgomery 1993; Mayeroff 1971) relatively few theorists mention it as an important dimension of ethic of care theory.

Sevenhuijsen (2003) and Baier (1986) claim that mutual trust is crucial to caring relationships, and that it is an important dimension of care that is mainly missing

from ethic of care theories. Baier (1986, p. 105) defines trust as ‘letting other persons take care of something the truster cares about, where such *caring for* involves some kind of discretionary power’. Baier (1986, p. 235) in particular draws attention to how trust and vulnerability go hand-in-hand explaining that ‘trust on first approximation, is accepted vulnerability to another’s possible but not expected ill will (or lack of goodwill) toward another’. Sevenhuijsen (2003, pp. 22-23) supports this view, arguing that trust always involves power. She argues that the trusted has a responsibility to use their power positively and creatively, in a manner that does not abuse the vulnerability of the other. Sevenhuijsen (2003, p. 23) maintains that it is important to understand that genuine care cannot be experienced without trust and that trust cannot be built without care, hence the two values are inextricably linked.

### **Criticisms of an ethic of care and responses**

Allmark (1995), a strong opponent of ethic of care theory argues that care ethics are hopelessly vague, and lack both normative and descriptive accounts. He says that ‘caring ethicists can tell us nothing of the ‘what’ and the ‘how’ which underlie our judgement’ (Allmark 1995, p. 21). One of the most common concerns about incorporating an ethic of care into the helping professions is that it may result in a paternalistic approach that can create co-dependency and strip people of their autonomy (Allmark 1995; Curzer 1993; Nelson 1992). This criticism is particularly raised by disability rights activists (Shakespeare 2000; Finkelstein 1998; Morris 1997). Morris (1997, p. 54) argues that care is a form of oppression against disabled people and not compatible with ideas of empowerment:

Care – in the second half of the twentieth century – has come to mean not caring about someone but caring for in the sense of taking responsibility for...People who are said to need caring for are assumed to be unable to exert choice and control. One cannot, therefore, have care and empowerment, for it is the ideology and the practice of caring which has led to the perception of disabled people as powerless.

It is for these same reasons that Shakespeare (2000) and Finkelstein (1998) reject the idea of an ethic of care, preferring a justice model that focuses on self-determination and rights.

Proponents of an ethic of care (Held 2006; Hankivsky 2004; Ververk 2001; Clement 1996; Tronto 1993) believe that critics of the approach often fail to interpret an ethic of care correctly. They argue that an ideal version of care requires that care and autonomy are mutually supportive and that an ethic of care does not preclude an ethic of justice. According to Clement (1996, p. 24), it is through relationship that autonomy is developed. She contends that by supporting and valuing the needs of the other, care can facilitate a shift, where the recipient of care moves from feeling powerless to feeling more powerful and in control. Tronto (1993) draws attention to the fact that many people who require care have limited autonomy, and it is through caring that autonomy is increased and a certain level of independence is reinstated. She also states that while people may be dependent during some times or in some aspects of their lives, this does not mean they are not autonomous at other times or in other situations. According to Ververk (2001, p. 291), a distinction can be made between autonomy being about self-sufficiency and independence and autonomy as having the power to make one's own choices in life. The latter does not necessarily preclude an ethic of care, whereas the former may (Ververk 2001, p. 292). Noddings (1995) asserts that if an ethic of care is approached in the 'right' way, from a position of genuine interest and concern for the other person, and with consideration for their needs as expressed by them, there are no grounds for having to defend an ethic of care against criticisms relating to paternalism and autonomy.

Another criticism of ethic of care theory is that it does not stand as a theory in its own right. Some authors (Paley 2002; Nagl-Docekal 1997) claim that the ethic of care is already inherent in Kantian ethics. Paley (2002, p. 140) states that both reason and emotion are important in Kant's ethical theory which argues that people have a duty to 'cultivate compassion' as well as a commitment to justice. While this may be a valid argument, Tronto (1993) highlights that the aspects of Kantian theory that align with ethic of care theory have been lost along the way and do not appear to be translated into professional codes of ethics. She claims that professional ethics have become primarily about an ethic of justice. Consequently, an ethic of justice has taken the dominant position in the public and professional realms, with an ethic of care taking a subordinate role at best and viewed as a weakness at worst (Tronto 2013, 1993).



Little (1998) understands care ethics as an orientation or perspective in the moral world, and claims that it is a useful stance to theorise from, rather than to be viewed as a complete theory in itself. According to Ververk (2001, p. 289), understanding care ethics in this way means that autonomy as a moral concept does not need to be abandoned, but instead ‘given a particular place and interpretation’. Tronto (1993) supports this view, arguing that moral judgements and actions must incorporate both perspectives of care and justice. She points out dangers associated with parochialism and partialities that arise when justice is not considered when applying a caring approach. An ethic of care necessarily involves engaging with each particular person and their unique needs, a local and concrete perspective. General approaches that take a broad, abstract view can potentially result in failure to recognise needs, as well as broader societal issues. While Tronto acknowledges that parochialism and favouritism are understandable and expected in the private realm of family and friends, she argues that they need to be minimised in the public and professional domains. She therefore advocates for a ‘political’ ethic of care that is connected to a theory of justice and that is approached in a democratic manner. Tronto (1993, p. 169) states her version of an ethic of care as:

Care as a political concept requires that we recognise how care – especially the question, who cares for whom? – marks relations of power in our society and marks the intersection of gender, race, and class with care-giving...These facts must be judged according to what a just distribution of caring tasks and benefits might be...There is a danger if we think of caring as making the public realm into an enlarged family. Family is a necessarily private and parochial understanding of caring...Care need not be associated with family in order to become a political ideal.

Just as an ethic of care is not a complete moral theory without justice, Tronto (1993) argues that justice cannot be properly served without care and without paying particular attention to the situation and needs of individuals through relationship with them.

While ethic of care theory has been the most influential theory of care within the social work literature, there are other theories needing mention in this review that challenge traditional ethics of justice and bear similarities to an ethic of care. These include Bauman’s moral theory and virtue ethics.

## **Bauman's moral theory and implications for care**

Zygmunt Bauman's (1994, 1993) moral theory compliments ethic of care theory.

Bauman (1993, p. 13) makes a clear distinction between morality and ethics, describing ethics as an attempt to codify morality, an attempt that in his opinion cannot work. He draws on Levinas' (1998) philosophical perspective on morality that argues that morality is about 'being-for' the other, that is, taking responsibility for the other in an unconditional way simply by virtue of them being human.

According to Bauman (1994, p. 19) 'it does not depend on what the other is, or does, whether s/he deserves my care or repays in kind'. Bauman (1993, p. 13) argues that a moral impulse underpins the human condition and the social nature of humanity.

According to this view, everyone has a natural awareness of morality in the sense that there are choices about the way we act in the world and 'the very fact that the question about the goodness or evil of human nature is asked (that it can be asked) is all the proof we need that this is the case' (Bauman & Tester 2001, p. 44). Bauman (1993) believes that this moral impulse precedes rationality and ontology, is fraught with ambiguity and uncertainty, and as such it is not possible to locate this idea in an objective reality.

Bauman (1994) refers to the divide that occurred during modernity between reason and emotion, when the moral world began to be measured by systematic laws, rules, principles and norms, and as a result the value of emotions was dispensed with. In an increasingly bureaucratised society 'everybody's actions must be totally impersonal, oriented to rules and specific procedure rather than persons' (Bauman 1994, p. 6). Such modernist organisational structures serve to 'strangle or criminalise moral impulses' (Bauman 1994, p. 13). He claims that even traditional ethics of the Kantian kind do not hold much weight in the current political context that values competitiveness, independence, cost effectiveness and profitability above all else (Bauman 2000, p. 9).

A sense of disenchantment with the post-modern world of relativity, ambiguity and increasing uncertainty infiltrates Bauman's writing (2000, 1994, 1993, 1992). Even traditional ethics of the Kantian kind are on the way to becoming redundant and are being replaced on one hand with an 'almost anything goes' approach and on the

other with an obsession with risk (Bauman 1994, p. 35). However, instead of being pessimistic about the collapse of traditional ethical ideals (ideals that he did not support in the first place) in the post-modern world, Bauman (1992) believes a space has been created for a new construction of morality. He argues for a morality that at its heart involves acting on the moral impulse to take responsibility for the suffering of others. Bauman's theory shares similarities with virtue ethics insofar as he indicates that the moral character of a person is important when attending to suffering. The next section draws on the literature that pertains to virtue ethics and explains its implications for care.

## **Virtue ethics and implications for care**

Virtue ethics date back to Aristotelian thought and are based on the central tenet that acting from virtue is sufficient to make a decision or action 'good'. Examples of virtues noted by Aristotle (2000) are temperance, patience, friendliness, courage, magnanimity and truthfulness. Van Hooft (1999, p. 190) refers to a virtue as:

A virtue is an ethical orientation of the self towards the world in characteristic ways. It is not manifest only in the behaviour of virtuous persons but is an aspect of their inner lives. Yet, a virtue is not just emotional or motivational and neither is it only a form of thinking. It is a component or orientation of the whole of our internal life, whether emotional or rational, and of our intentional actions.

Virtues are that which motivate a person, that do not simply arise from a sense of duty, and that reflect a moral character (Hugman 2005; McBeath & Webb 2002; Aristotle 2000; MacIntyre 1981). Vanlaere and Gastmans (2007), Halwani (2003) and van Hooft (1999) contend that when care stems from a caring disposition of character and is informed by the needs of the care recipient, then it constitutes a virtue. In spite of this idea that care can be viewed as a virtue, some care ethicists (Held 2006; Noddings 1984; Gilligan 1982) argue that virtue ethics and an ethic of care are not compatible due to virtue ethics emphasising the moral value of individual character traits rather than focusing especially on relationships and the needs of the one being cared for. Held (2006, p. 4) states:

There are similarities between the ethics of care and virtue ethics. But in its focus on relationships rather than dispositions of individuals, the ethics of care is, I argue, distinct.

Conversely, Thomas (2011), Sander-Staudt (2006), Halwani (2003) and Slote (1998) argue that virtue ethics and care ethics are complimentary. As Thomas (2011, p. 138) maintains, while virtues exist within the individual, the enactor of a virtue must consider its impact on others. Thomas (2011, p. 139) contends that Aristotle's version of the 'good life' cannot be achieved through egoistic means, and that 'whether things go well or badly for you depends on whether things go well or badly with those to whom you stand in relationship with'. According to Thomas (2011) the relationship is equally important from the perspective of virtue ethics. In addition, virtue ethics enhances an ethic of care by ensuring that a caring motivation precedes the relationship (Thomas 2011; Slote 1998). This is important in Thomas's (2011, p. 148) view as he argues that an ethic of care places emphasis on relationship as if it exists in isolation, without considering that first care must be directed towards the person that one is in relationship with. He illustrates this point as follows:

It is the 'object' that is important to the caregiver; if I love my wife, it is my wife I love and not the relation in which I stand to her. I don't love my wife in virtue of loving love. It is valuable that the relation is instantiated and that is not the same as claiming that the relation is the highest value (Thomas 2011, p. 148)

While virtue ethics and an ethic of care offer distinct ways of viewing care from an ethical perspective, it is apparent that they can work together to create a rich conceptualisation of care that values caring character traits and motivation as well as the relationship that care is situated in.

## **Concluding Comments to the Chapter**

In this chapter I have considered various definitions of care in the public world, and more specifically the helping professions. The nursing literature offers valuable insights into how care is understood and applied to social work practice, particularly in light of the limited writing on this topic in the social work literature. The empirical research conducted with nurses and patients suggest that care does not only involve meeting practical needs: demonstrating genuine concern, forming relationships with patients and meeting emotional needs are important indicators of care. I have discussed the basis of ethic of care theories and explained how theorists have used these ideas to ground care in a coherent moral framework. Criticisms of

an ethic of care have been outlined and responses to these criticisms have been examined. I have shown how Bauman's (1994, 1993) moral theory and virtue ethics both contribute to understandings of care and link to ethic of care theory. In the following chapter I present the current thinking within social work scholarship on the role of care in direct social work practice and highlight the gaps that led to my research question.

# **Chapter 3: A Critical Perspective of Care in Professional Social Work**

## **Introduction**

The focus of the previous chapter was on debates about the meaning of care; how care is enacted in the public world, with particular reference to views of caring practice in the nursing profession; and moral and ethical theories of care. In this chapter I focus on care as it specifically relates to direct social work practice. The chapter is divided into two main sections. The first section explores theories and arguments that relate to the role of care in the contemporary professional social work context. I begin this first section of the chapter with a brief overview of the social work profession, defining social work, its purpose and the core values that underpin the profession. The history of care in the social work profession is then presented. This is followed with a presentation of literature that discusses care as it relates to the contemporary professional social work context. This is a professional context that continues to be informed by scientific evidence based practice and is heavily influenced by the ideals of neoliberalism and New Public Management. It is evident that most social work academics who have taken an interest in the role of care in social work practice promote the incorporation of an ethic of care to ensure that care does not become lost in an increasingly bureaucratised context, as well as a means of countering the negative effects of managerialism (Dybicz 2012; Gray 2010; Banks 2006; Parton 2003). I explore these ideas that promote the incorporation of an ethic of care into social work practice. I conclude the first half of this chapter by reviewing Bauman's (2000) recommendations for implementing a more caring social work profession.

In the second half of this chapter I focus on the empirical research that has been conducted on care in direct social work practice. Due to the limited amount of social work research literature available on this topic some of the studies reported in the nursing literature have been included here, based on the assumptions that there are

similarities in the way the two disciplines conceptualise care. The few studies that do explore social workers' care in practice and clients' experiences of care are also presented in this section. The chapter progresses to explore research that argues that while social workers often find it difficult to care in contexts that are heavily managed and controlled, they find ways of resisting constraints and continue to care despite the challenges. Clients' accounts of uncaring social work practice become particularly obvious in this section, highlighting the importance of gaining the client perspective in research. This chapter ends with my reflection on the need for further research that provides a deeper, more comprehensive understanding of how social workers care and how clients experience care in direct practice in order to consider how ethic of care theory does, and can, inform practice. The chapter concludes with a statement of the aims and research questions that have guided this study of caring practice.

## **Theorising the Role of Care in Social Work Practice**

### **Overview of the social work profession**

The International Federation of Social Work (2014) provides the following definition of social work on their website:

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.

This research focused on direct practice in social work, that is, practice that involves all aspects of working directly with individuals, families, groups and communities. Direct practice includes methods of intervention, interpersonal skills, professional communication, and conducting assessments and making decisions about appropriate interventions (AASW 2003, p. 7). Direct practice both informs and is informed by research and policy (Hepworth, Rooney, Dewberry Rooney & Strom-Gottfried 2013,

p. 33). While aspects of care that have been discussed in Chapter 2, such as empathy, compassion, deep listening and genuineness are embedded in many models of direct social work practice, explicit mention of care as a concept and/or ethical concern remains absent. Yet, care was a defining feature of the practice of the earliest social workers as highlighted in the next section of this chapter.

### **The history of care in the social work profession**

A review of the literature on the history of social work shows that the profession was deeply steeped in the idea of care from the outset. The first social workers were female volunteers who belonged to either the Charity Organisation Society (COS) or the Settlement House Movement, both of which were set up in the late 19<sup>th</sup> century (Lymbery 2001, p. 370). The Settlement House Movement was established in order for educated people to assist those living in poverty to improve their lives through education and leadership (Lymbery 2001, p. 371). The COS was a Christian based organisation driven by a strong moral purpose to help those in need (Lymbery 2001, p. 371). Dybicz (2012, p. 271) argues that both the COS and Settlement House Movement workers expressed care through a genuine friendship with those they were helping. Relationships were built on trust and respect for one another. However, not every person living in poverty was considered to be deserving of help during those early days (Lynn 1999, p. 941). The COS functioned according to a moral code that distinguished between the ‘undeserving’ (those who may have committed criminal acts and/or be given to violent and abuse outbursts), the poor and the ‘deserving’ (the meek and well-behaved) poor, based on judgments about moral character (Lynn 1999, p. 941).

The COS has been criticised for regarding poverty as a problem of the individual rather than recognising social inequalities and the impact that environmental factors had on the lives of people, rendering the care they provided conditional (Lynn 1999, p. 941). The Settlement Movement was more focused on the social causes of poverty resulting in a more unconditional delivery of care (Lynn 1999, p. 941). Weick (2000, p. 45) points out that while debates continue to rage over whether social work was and continues to be more about social control than genuine concern



for the suffering of those less fortunate, moral overtones did not prevent these women from 'being with' the people they worked with. She says:

The poor were sinking under abominable living and working conditions...the sights, smells, cries and triumphs were a palpable part of these encounters. This earthly connection with people's lives, although constrained by the formality of class difference, set the direction for social work practice (Weick 2000, p. 399).

Mary Richmond, originally a 'friendly visitor' with the COS was one of the first to advocate for social work as a credible profession, leading to a shift from charity work to scientific, theory-driven, formal casework (Ginsberg & Miller-Cribbs 2005, p. 22). Along with this change, which began during the early 20<sup>th</sup> century, an emphasis was placed on replacing emotions with an objective, detached interest in the 'object' of study (Freedberg 1993, p. 536). Freedberg (1993, p. 538) argues that it was not Mary Richmond's intention to undermine the humanistic aspects of social work. Instead this change was in response to scientists (mostly male) regarding caring as 'sentimental women's work' that was not compatible with science and critical inquiry.

Throughout the ensuing decades care continued to be undermined in social work practice as the profession became increasingly focused on scientific, evidence-based assessments and interventions (Freedberg 1993). A resurgence of interest in relationship-based practice was evident in the 1950s and 1960s, particularly as a result of Carl Rogers' (1951) 'person-centred' approach to case-work. Rogers emphasised principles such as empathy, unconditional positive regard and genuineness, all of which continue to guide social work practice today and remain key elements of the social work professions' code of ethics (AASW 2010). While humanist values have survived, they have largely remained on the periphery of social work theory and policy (Freedberg 1993). In the first of moves away from Rogers' humanist approach, during the 1970s and 80s social work became less focused on reflexive/therapeutic approaches and more concerned with challenging social inequalities and addressing macro issues (Lymbery 2001, p. 371). In more recent times an individualist approach that is line with the neoliberal political context has begun to dominate – a context that does not challenge social structures, or pay particular attention to relationship (Ferguson 2008). Instead, an individualist

approach aims to reform and educate people in the ways of responsible, independent, neoliberal citizens (Ferguson 2008; Lymbery 1998; Payne 2006).

Weick (2000) argues that attention to care in social work, while diluted to a great extent over the last 100 years, has never really disappeared altogether. She explains:

The essential voice of social work has not been permanently lost. As is true of all expressions of experience not represented in the dominant language, they ride under the surface of conscious thought, always present but carefully disguised under layers of doubt and guilt and misgiving. It is still found most fully in what we call 'practice wisdom', the accumulation of knowledge that is flavoured with the richness and intricacies of years of collective practice experience. It includes the warm waters in which human connections are forged... These qualities of good practice give hope and shed light on the murky and troubling circumstances in which human beings often find themselves (Weick 2000, p. 400).

Talk of care as a concept in its own right has only become a topic of significant interest in the social work literature since the early 2000s (Dybicz 2012; Gray 2010; Banks 2006; Webb 2006; Hugman 2005; Meagher & Parton 2004; Parton 2003) and has primarily been discussed in terms of 'an ethic of care'. Many of these authors (Gray 2010; Lloyd 2006; Webb 2006; Hugman 2005; Meagher & Parton 2004; Parton 2003) express concern that caring values that have always been embedded in social work practice, even if not always explicitly highlighted as important, are at risk of being lost altogether in an increasingly managed and controlled profession. It is this concern that seems to have prompted recent discussion on this topic and is summed up by Jones and Novak (1993, p. 211) as:

It would appear that until the political climate changes and there is a widespread revulsion against current trends and inequalities, social work might continue as an occupation, but perish as a caring and liberal profession.

## **The contemporary professional social work context and its consequences for caring practice**

This section explains what is meant by New Public Management and neoliberalism and the impact they have on 'caring' social work practice. The professional social work context is largely embedded in neoliberal philosophy and driven by the policy of New Public Management.

The term 'New Public Management' was first coined by Hood (1991), who describes this phenomenon as a management style designed to monitor, assess and regulate the performance of both workers and clients with the main aim being to control economic cost. New Public Management is a marketised approach to public services, including welfare services (Banks 2011). Some of its main features include: attention to outputs and efficiency rather than inputs; an emphasis on competition between organisations to enable choice by service users; decentralisation of budgetary and personal authority to lower management (Clarke, Gewitz & McLaughlin 2000); and increased accountability in terms of time management, following procedures and producing profitable outcomes (Banks 2004).

New Public Management has evolved as a result of a lack of confidence in the ability of governments to effectively and efficiently deliver public services, which has led in turn to a shift from public service to the private management of services (Webb 2006, p. 172). According to Meagher and Parton (2004, p. 14), the managerialist perspective views professionals as self-interested and untrustworthy and as such require strict boundaries and criteria of accountability. New Public Management is informed by the values of the political philosophy of neoliberalism including individualism, freedom of choice, market security, independence and self-responsibility (McDonald 2006, p. 63). Neoliberalism has produced a shift away from the welfare state towards public responsibility and participation (McDonald 2006, p. 63). The ideal manager remains distant and controlled, taking a critical stance towards arguments presented, drawing his or her own conclusions based on designated general rules (risk assessment, cost-benefit analysis and so on) rather than being swayed by emotions (Meagher & Parton 2004, p. 14).

Bauman (2000) presents a scathing critique of the direction the social work profession is heading in, arguing that the ideals traditionally held by the profession itself and the reality imposed by an increasingly bureaucratised neoliberal society, are worlds apart. He argues:

The proper task of social work ought to be, we are told, getting rid of unemployed, handicapped, invalid and other indolent people who for one reason or another cannot eke out their own living, and depend on social help

and care for their survival... 'Dependence' has become a dirty word: it refers to something which decent people should be ashamed of (Bauman 2000, p. 5).

The next section of this chapter focuses on how an increasingly bureaucratised society impacts on social work practice, particularly in regard to 'caring' practice.

### **The impact of New Public Management and neoliberalism on caring practice**

Critics contend that the introduction of New Public Management has in some ways benefitted the social work profession. Lonne, McDonald and Fox (2004, p. 3) point out that an increased emphasis on efficiency has resulted in savings in some areas and allowed for funds to be distributed across other areas that previously received little support or attention. According to others (Fook, Martin & Hawkins 2000; Healy 2000), increased accountability measures have also led to a reduction in the abuse of professional power and consequently enabled clients to hold more power and choice. An example of this is the Australian Home Care Packages Program (Australian Government Department of Social Services 2014) which was introduced to support older Australians with health and disability issues to continue to live independent and active lives. The main objectives of this program are to 'assist people to remain living at home' and 'to enable consumers to have choice and flexibility in the way that consumers' aged care and support is provided at home' (Australian Government Department of Social Services 2014, p. 6).

Mostly scholars paint a grim picture of the impact that New Public Management and neoliberal ideologies have had on the social work profession. Webb (2006, p. 55) describes social workers under this regime as 'servants of an entrepreneurial ethos'. He contends that social work could 'no longer legitimate itself through ethical claims such as the helping or caring ethic, but is judged according to its capacity to produce results', mainly economic results (Webb 2006, p. 173). Evetts (2003) supports these views contending that New Public Management poses a serious threat to the professions as they are experiencing less autonomy and control over their work. As Lymbery (2001) argues, this is particularly the case for social work as it has never

held the professional status of other professions and has largely been located in the hierarchies of state bureaucracies.

There has been criticism of New Public Management's definition of 'evidence based practice' which focuses on 'research evidence' (Gambrill 2011; Munro 2011; Trevithick 2014, 2008). As Trevithick (2014) argues, New Public Management does not give merit to other forms of credible evidence, such as knowledge, skills and practice wisdom held by professionals, or the knowledge or personal experiences of service users. She contends that managerialism ignores the value of the helping relationship in service provision. New Public Management needs to be 'humanised' if it is to truly meet the needs of service users and this can only happen if 'emotionally responsive relationship-based practice' (Trevithick 2014, p. 307) is placed at the centre of social work practice. This would involve allowing social workers to spend more time connecting with clients and assessing not only 'what' is happening but also why, as opposed to 'ticking boxes' and fitting people and their problems into fixed categories (Trevithick 2014; O'Leary, Tsui & Ruch 2013).

As it is social workers are increasingly working in contexts with people who do not understand or support a relationship based perspective of social work (McDonald 2006, p. 99). A poignant example is provided by McDonald and Chenoweth (2009) who explain the difficulties that social workers situated in income support agencies face in challenging the values and rationalities of the Australian 'Welfare to Work' policy, a policy that others within the organisation accept at face value. As Stanford and Taylor (2013, p. 482) highlight, identifying unemployed people in a way that insinuates they are not meeting their obligations to society, fails to acknowledge the layers of disadvantage that many of these people are subject to, and that it is privileged groups who have created such inequalities in the first place. Assumptions that life outcomes are largely a result of choice neglect to consider that many of the people that social workers come into contact with face structural barriers that limit choice and make it difficult for change to occur (Tronto 1993). Webb (2006, p. 56) argues that it is the middle class who benefit most from neoliberal policies.

Bauman (2000) expands on these concerns, contending that humanity and morality have all but been extinguished in a society in which science, competitiveness and

profitability 'rule supreme'. Bauman (2000, p. 5) sees this way of thinking as immoral and antithetical to social work ethics and values. He believes that recognition of dependence is a pre-requisite for morality and that questioning dependence or needing to justify care renounces all moral responsibility. He argues that the current context fails to consider that neither human suffering nor happiness can be measured by profitability, level of independence or so called choice. Bauman (2000, p. 9) claims that the demise of the welfare state is inevitable without a return to the ethical argument and recognition that 'the essence of morality is the responsibility people take for the humanity of others'. While Bauman (2000, p. 11) acknowledges that efforts to re-incorporate these ethical ideals back into the welfare state may continue to be ignored and/or rejected, he believes the effort must be made regardless:

The future of the welfare state, one of the greatest gains of humanity and the foremost achievement of civilized society, lies on the frontline of an ethical crusade. That crusade might be lost – all wars involve a risk of defeat. Without it, however, no effort stands a chance of success.

Smith (2011, p. 13) supports Bauman's view, asserting that 'in essence, social work needs to be reconceptualised as a moral rather than an instrumental task'. Morality in this sense is referred to as a caring 'orientation towards the other' as opposed to an ethical stance that attempts to codify morality (Smith 2011, p. 14). Parton and O'Byrne (2000) agree that social work is primarily a moral activity rather than a technical enterprise. They advocate a constructionist approach to social work that is client-centred, process oriented and open to new ways of thinking (Parton & O'Byrne 2000, pp. 182-183). They contend that scientific standards and pre-conceived goals are often incompatible with the ambiguous, uncertain world of social work practice. Thus, it is theorised that today's political climate places the core values of social work in a precarious position and according to Bauman (2000), Smith (2011) and Parton and O'Byrne (2000), codes of ethics are not sufficient to counter the new morality that is based on economics rather than people. They argue that it is necessary to return to a morality that is based on responsibility to others.

Linked to these views of care as a moral concern is Morley and Ife's (2002) contention that a 'love of humanity' can aid in countering the rationality based on

economics that is embedded in the contemporary social work context. They express a view of love that transcends the conventional use of the term and can relate to social work practice. Morley and Ife (2002, p. 69) explain:

Love is one of the most fundamental human emotions, and social workers might be seen as in the business of expressing love, not in the intimate, private sense of the word, but in terms of a more generalised 'love of humanity'.

Morley and Ife (2002) draw attention to a lack of reference to love in the social work literature, believing that the use of the word is incorrectly viewed as inappropriate in the rational, professional world. Implicit in the idea of a 'love of humanity' is the basic idea that everyone shares a common humanity, which means that at least in this sense, everyone is equal. To love is to feel and acknowledge common humanity, and as such provides powerful connections between the client and their private struggles, and social workers in their public and professional role (Morley & Ife 2002, p. 75). To explain further, a 'love of humanity' approach dispels all assumptions about human experience except that 'our humanity connects us, despite the limitations imposed by privilege and under-privilege' (Morley & Ife 2002, p. 76). Ultimately Morley and Ife (2002, p. 77) argue that 'humanity is more important than the inhuman systems that try to control and shape it'.

## **Introducing an ethic of care into contemporary social work practice**

In order to understand social work's current position on ethics, it is important to have a thorough knowledge of the professional code of ethics. As identified by Gray (2010, p. 1796), the AASW Code of Ethics (2010) continues to focus mainly on deontological principles such as respect, justice and human rights.

Gray argues that while such principles are important, it may be equally important to consider incorporating an ethic of care. Meagher and Parton (2004, p. 22) support this stance, maintaining that practising social work in an ethical manner requires much more than applying principles. They contend that along with a commitment to social justice there should be a commitment to care. Important components of ethical decision making include a preparedness to emotionally connect with people, understanding of the uniqueness of each person and awareness of the complex and

often subtle factors that differentiate experiences and circumstances (Meagher & Parton 2004, p. 23).

One small change has been made to the most recent edition of the AASW Code of Ethics (2010), with the glossary of terms including a mention of care when defining 'competence'. The previous edition (2002, p. 24) defined competence as:

Involving acquiring and continuing developing knowledge, skills and experience to provide a professional, effective service which reflects the values expressed in the profession's Code of Ethics.

This definition was changed in the 2010 edition of the *AASW Code of Ethics* (p. 42), citing a quote from Banks and Gallagher (2009, p. 104), which reads:

This is about care-giving, the actual work of care that needs to be done – one's ability to do something about another's needs. The term 'competence' is being used here in a holistic sense relating to professionals' abilities and capacities, rather than a set of discrete technical skills (competencies).

This new definition indicates that a recent interest in the notion of an ethic of care is being given at least some consideration by the profession. It should be realised however, that this mention of care is very brief and does not appear in the main body of the AASW's Code of Ethics (2010). Furthermore it can be argued that this definition appears to relate more to care as action, excluding the 'caring about' that ethic of care theorists claim to be crucial to an ethic of care.

The term 'duty of care' is also used twice in the document (AASW Code of Ethics 2010, pp. 12, 15). Like the concept of 'care', Duty of care' is another taken-for-granted term with no definition provided in the Code of Ethics (2010) and minimal definitions are provided elsewhere in the social work literature. This is in spite of its ubiquitous use in social work and policy documents. McAuliffe (2014, p. 123) defines duty of care as, 'a legal obligation imposed on an individual and that requires that they adhere to a reasonable standard of care when engaged in the performance of actions that could potentially harm another'. The UK Social Care Institute for Excellence (2014, p. 1) defines duty of care as, 'a legal obligation to always act in the best interest of individuals and others, to not act or fail to act in a way that results in harm, and act within competence...'. These definitions indicate that a duty of care is very different to an ethic of care, the aims of which extend far beyond safety and



avoidance of harm to creating connections with people through deep listening, understanding the unique experiencing of the other, and attempting to meet individual and unique needs. Chenoweth and McAuliffe (2014, p. 16) have more closely aligned the idea of 'duty' with an ethic of care in their definition of social work where they say: 'They (social workers) are further charged with the duty to respond with passion, hope and care, to human need wherever and however it is manifested'.

Social work academics (Barnes 2012; Dybicz 2012; Gray 2010; Gregory 2010; Clapton 2008; Lloyd 2006; Webb 2006; Meagher & Parton 2004; Parton 2003) have responded to concerns that care is at risk of being lost in the contemporary professional context. They contend that incorporating an ethic of care into social work practice and policy may be an effective means of countering the deleterious effects of New Public Management and neoliberalism. Meagher and Parton (2004, p. 11) argue that an ethic of care 'offers ways of conceiving and representing the relational dimensions of social work that are increasingly becoming obscured by the rational-technical focus of managerialism'. As Webb (2006, p. 74) claims, standardised assessment tools used by many organisations are subject to error as social life can rarely be reduced to universal, rationalist modes of thought and often fail to consider the complexities and changing nature of problems or the interaction between variables (Webb 2006, p. 74). Parton (2003 p. 2) echoes Webb's argument, pointing out that much of social work practice is practical, concrete and intuitive, describing such practice as a form of art – an art that is in danger of being lost as rational-technical approaches take over. Parton (2003, p. 13) states:

While evidence based practice has an important place in social work, there is also room for the plurality of knowledge and voice and the relational quality of knowledge which is supported by an ethic of care.

Dybicz (2012, p. 271) promotes this view, arguing that 'care provides a necessary buffer to what would otherwise be the sterile application of scientific knowledge'. He asserts that purely applying scientific knowledge can result in dehumanising and de-valuing the client, whereby the client is treated as a category rather than a unique being. While Dybicz (2012) does not undermine the value of scientific knowledge and evidence based practice, he does contend that the relationship should not be dismissed as irrelevant or less important.

Featherstone (2010, p. 83) expresses some concerns about the incorporation of ethic of care theory into social work practice, claiming that an ethic of care is too abstract and difficult to define. In relation to social work practice she wonders how it can be assured that an action is 'right' or 'wrong' without specific criteria to guide actions, arguing that good intentions alone may not be enough (Featherstone 2010, p. 84). Featherstone and Morris (2012, p. 353) also voice fears that an ethic of care in social work practice 'can be used to pit care against justice, reinforcing rather than interrogating difference'. While these are important considerations for a profession that has worked tirelessly to promote social justice, as several authors (Held 2006; Heckman 1999; Jagger 1995; Tronto 1993) contend care and justice are compatible and inseparable, and the two do not have to be in conflict with one another. This problem is addressed by Edelman & Mandle (2006), (Gray & McDonald) 2006 and Parton (2003), who argue that by incorporating professional judgement based on professional knowledge and prior experience into an ethic of care approach, potential harm can be minimised. Bauman (2000, p. 10) responds to arguments such as these by claiming that uncertainty and risk necessarily always accompany moral decision making, denoting one of the differences between ethics based on universal rules and principles and true morality. He asserts that:

If the demand for responsibility and care could be spelled out in detail, as – tired of perpetual uncertainty – we so often dream, the demand would be purely an external matter, without any responsibility on our part, without any investment of our own humanity, imagination of insight...absolute certainty is the same as absolute irresponsibility (Bauman 2000, p. 10).

While Bauman recognises that following a morality based on care is not easy for social workers, he nevertheless renders it important. Banks (2008) supports this view, while at the same time acknowledging that much of the writing on care in social work practice is speculative and does not provide a detailed approach for practice. She argues that this is not surprising, as it is a difficult task given the abstract nature of the concept and the complex world of social work practice that it needs to fit into. Banks (2008, p. 1243) calls for the publication of book-length works, outlining what an ethic of care would look like in practice. Such work is yet to be presented. Thus far this literature review has presented the theory that informs thinking about care in general and in relation to social work practice. I progress the

next section of this chapter by presenting the empirical research on care as it specifically relates to social work practice.

## **Researching Care in Social Work Practice**

While many of the studies presented in this section were not specifically designed to investigate care as a concept in its own right, they all provide insights into aspects of caring practice. This body of research is critically analysed and gaps are highlighted in order to contextualise the focus of the study reported in this thesis. The following section begins with empirical research on social workers' views and experiences of care in practice, which is followed by an examination of the client's perspective.

### **Social workers caring in the contemporary context of practice**

Empirical studies support arguments that a significant tension exists between managerialism and the values and practises of social work. An emphasis on recording, information gathering, risk management and meeting targets restricts creative practice and the ability to connect with clients (Barnes 2012; Gregory 2010; McDonald & Chenoweth 2009; Baines 2006; McDonald 2006; McDonald & Marston 2006). Studies of Australian Centrelink social workers revealed that social work values were compromised due to workers being forced to meet the agenda of work reform rather than the specific needs of the client (McDonald & Chenoweth 2009; McDonald & Marston 2006). McDonald and Chenoweth (2009, p. 157) were disturbed to find that social workers frequently provided distressing accounts of the personal toll of working within a value system that conflicted with their own. They reported the following response as typical:

I am tired and I have headaches daily. I am unable to have conversations about welfare. I have lost my passion. It is increasingly difficult for me to continue to feel positive (McDonald & Chenoweth 2009, p. 157).

Barnes (2012) interviewed social workers who worked with young people in out-of-home care in the United Kingdom. Participants spoke about the lack of 'quality time' they had to spend with their clients, explaining that other demands of their work had 'squeezed out relationships', resulting in them feeling more like administration officers than social workers (Barnes 2012, p. 1283). The value of

relationship in social work practice was highlighted in a report compiled by The Scottish Executive (2006). After speaking to social workers across Scotland over a 12 month period the report (2006, p. 31) states:

Working to achieve change is at the heart of what social workers do. Identifying needs and risks through developing and implementing action plans will achieve nothing without an effective therapeutic relationship between worker and client... Yet social workers consistently told us that it is this very aspect of their work which has been eroded and devalued in recent years.

In spite of the difficulties posed by the neoliberal political context and New Public Management, it is evident within the literature (Gregory 2010; McDonald & Chenoweth 2009; White 2009; Stanford 2008; Meagher & Healy 2003; Vonk 1999) that social workers continue to find ways to be led by values that are in line with an ethic of care. Meagher and Healy (2003) revealed that social workers working in family support services valued care and ranked the needs and goals of the client above the goals of the organisation. Workers in the youth justice system expressed concern that the justice system and the required adherence to targets are irrelevant to their work believing that their assessments and decisions need to be based on recognising the unique situation of clients (Gregory 2010, p. 2286).

Social workers have also been shown to resist the conservatism of New Public Management by taking risks of their own. Social workers in Stanford's (2008) study recognised and acted upon their sense of a moral responsibility to their clients, sometimes overriding their organisation's abstract rules and principles. As Stanford indicates (2008, p. 218), this attention to relationships with clients and the way in which social workers rationalise their decisions can be seen as a demonstration of an ethic of care. Gregory (2010, p. 2281) interviewed probation workers who were also social workers, finding that social workers continue to use professional judgement and make their own assessments based on the client's circumstances while merely appearing to follow the narrow procedures of evidence-based practice and risk assessment. Some social workers refuse to be silenced by management in spite of the difficulties it may pose, continuing to advocate for their clients and making their professional views known (McDonald & Chenoweth 2009, p. 159).

After speaking to social workers from child protection organisations, Thomas and Davies (2005) revealed subtle acts and behaviours of resistance. Social workers spoke about sometimes deliberately leaving decisions about cases such as accommodation for children until Friday afternoon, so that usual protocols and processes around decision making had to be bypassed or cut short, effectively manipulating managers into taking a particular course of action (Thomas & Davies 2005, p. 727). Participants of Greenslade, McAuliffe and Chenoweth's (2014) study of social workers working in a variety of statutory roles shared similar stories. Greenslade, McAuliffe and Chenoweth (2014, p. 7) identified 'covert resistance' to rules and regulations that did not fit with social work values, with one social worker explaining how after noticing that her notes seemed to mysteriously 'disappear' from files she began to write on the back of existing case notes to ensure that the notes remained in the file. Approximately 10 per cent of the participants in McDonald and Marston's (2006, p. 179) study described the Centrelink workforce participation agenda in a positive light, viewing it as an opportunity to follow up with clients. While they were meant to focus on discussing participation, they also used this time to attend to other needs and concerns.

On examination of the existing research, it is evident that many of the social workers who participated in these studies aimed to find a balance between enacting an ethic of justice and an ethic of care. The participants in Gregory's (2010) study argued that there are ways of providing care for offenders while at the same time supporting and protecting victims as well. They remained committed to balancing the demands of both justice and care. Vonk's (1999, p. 49) case-study of a social worker supporting survivors of sexual assault found that the practitioner demonstrated both an ethic of care and an ethic of justice. The practitioner informed the victim of the police's rationale for her pressing charges against the perpetrator, but also acknowledged the impact this may have had on the client, explaining that the decision was up to the client and she would not try to sway her decision either way. While the studies to date about the incorporation of care in social work practice provide some clues and justification for its relevance, the research remains scant. A more in-depth exploration of how care is enacted with concrete examples of caring practice and the challenges faced is required in order to inform an ethic of care for contemporary direct social work practice.

## **Clients' experiences of caring and uncaring social work practice**

The quality of the social worker/client relationship has considerable impact on the client's experience and level of satisfaction with the interaction. None of the studies found throughout the social work literature reported directly questioning clients about 'care' per se. Holland (2010) did use ethic of care theory to inform her research that investigated formal and informal caring relationships that young people in state care were involved in, including with social workers. While she chose not to explicitly use the term 'care' when asking participant's questions, a sense of how care was conceptualised and practised in the participants' lives was gained. Other studies have focused on client views of the social work/client relationship (Holland 2010; Beresford, Croft & Adshead 2008, 2007; Maiter, Plamer & Manji 2006; Drake 1994); views on what is most helpful from a social work interaction (Manthorpe, Moriarty, Rapaport, et al. 2008; Ribner & Knei-Paz 2002); and consumer participation (Beresford, Adshead & Croft 2007; Bland, Laragy, Giles & Scott 2006; Beresford & Croft 2001). Many of these studies provide information that is compatible with ideas around care in general as well as an ethic of care. These studies are therefore helpful in order to gain an idea of how social work clients may perceive care in practice.

The elements that appear to be most valued in the relationship between clients and social workers include being put at ease, being non-judgmental, using active listening, empathy, acceptance, genuineness, continuity of support, meeting needs and client involvement in assessment processes and decision making (Holland 2010; Maiter, Palmer & Manji 2006; Ribner & Knei-Paz 2002). Beresford, Croft and Adshead (2008, 2007) refer to the way patients and family members of the bereaved involved in specialist palliative care social work speak about social workers as 'friends'. It was an unexpected finding that service users repeatedly used the word 'friend' when describing their social worker, in which friendship was seen to be a valued part of the relationship (Beresford, Croft & Adshead 2008, p. 1394). Friendship was viewed in two ways: as involving 'reciprocity' and 'flexible professional relationships'. These ideas are reflected by one female participant who is quoted as saying:

It seemed unfair to tell [the specialist palliative care social worker] everything about me. I wanted to say well how are you today? ...and you know I wanted to, she was much more of a friend as time went on but also she was still my counsellor, you know she still kept the professional situation (Beresford, Croft & Adshead 2008, p. 1395).

Beresford, Croft and Adshead (2008, p. 156) acknowledged that the term 'friend' is generally avoided in the social work profession due to concerns that boundaries will be crossed, threatening professional identities and competence. Nevertheless, the reality is that many participants used the word 'friend' often and believed the friendship they developed with their social workers to be crucial to feeling that they could be open and honest, as well as open to advice and constructive criticism from the workers themselves (Beresford, Croft & Adshead 2008, p. 158). Similar ideas were presented in Ribner and Knei-Paz's (2002, p. 382) Israeli study, with participants describing a sense of closeness with the social worker as helpful in terms of feeling comfortable and open. Some spoke of their social worker as 'like a friend', others said that their social worker was 'like a mother', and two of the 11 participants used the phrase 'like a sister' (Ribner & Knei-Paz 2002, p. 382). Indications of such closeness were demonstrated by such things as not feeling inferior to the worker, 'laughing with us' and 'speaking freely' (Ribner & Knei-Paz 2002, p. 383). Being given time and accessibility were also of central importance to participants in Beresford, Croft and Adshead's studies (2007, 2008). It was reported that while participants acknowledged that social workers were busy and under considerable pressure, they expected the workers full attention when with them. A participant explained:

She's got so many other things she's got to be doing, but then she'll sit down and talk to you as if you are the only person there that she is involved with (Beresford, Croft & Adshead 2007, p. 96).

Conversely, studies have reported that clients perceive certain attitudes and behaviours as unhelpful and/or upsetting. These include depersonalising clients by treating them as simply files or cases, coming across as cold and uncaring, being critical and negative, and not appearing to be attentive to or understanding of individual needs (Beresford, Adshead & Croft 2007; Maiter, Palmer & Manji 2006; Drake 1994). While some of the young people in Holland's (2010) study had positive stories to share about their relationships with child-protection social

workers, generally the comments were negative. It was often felt that social workers didn't care about the clients, they didn't have the time or the inclination to listen to particular problems they were facing, and they were more concerned with getting the job done as quickly and efficiently as possible. Holland (2010, p. 1676) quoted a 17 year old female participant who said:

She said (the social worker) to my mother 'you may start off liking me, but I do get to be a little cow and you may hate me in the process of being the social worker' and she went, 'but I'm used to it by now so I don't care what you think of me. I'm still her social worker and I'm still yours'. I was like, that cheesy little cow, bog off, I already do hate you, get away from me. I won't let her do nothing for me.

Holland (2010, p. 1678) added that participants focused on issues of fairness and rights along with relationships and care, indicating that an ethic of justice also played a role in the young peoples' discussions about their experiences.

Beresford, Adshead and Croft (2007) spoke with study participants prior to their experience with palliative care social workers, exploring participants' views of social workers based both on pre-conceived ideas as well as direct past experience. They found that participants generally held negative views of social workers as interfering, controlling, manipulative, intrusive and difficult to access (Beresford, Adshead & Croft 2007, p. 51). A father spoke about how past experiences with social workers had 'scarred him for life', resulting in him being reluctant to allow support for his young daughter on the death of her mother (Beresford, Adshead & Croft 2007, p. 47).

Throughout many of the studies conducted (Holland 2010; Beresford, Croft & Adshead 2008, 2007; Bland, Laragy, Giles & Scott 2006; Riber & Knei-Paz 2002; Palmer, Brown, Rae-Grant & Loughlin 2001) clients have spoken about feeling demeaned and devalued by social workers and how they perceived actions and attitudes as often antithetical to care. Arguments against such practice have become prominent in the mental health literature in recent years (Bland, Renouf & Tullgren 2009; Bland, Laragy, Giles & Scott 2006). These authors emphasise the importance of 'consumer participation' and understanding the 'lived experience' of the client. Consumer participation is defined as 'any activity done by consumers where they have power or influence on the systems and services that affect their life' (O'Hagan



2000 as cited in Bland, Renouf & Tullgren 2009, p. 48). Ann Tullgren (2009), a mental health consumer, social worker, advocate for mental health consumers and author, indicates that without care mental health social work does more harm than good. She provides the following advice to social workers in regard to caring and valuing consumers' knowledge and experiences:

How I experience my symptoms may be different from how they are described in your textbooks. Would you like me to tell you about this? ...I'm a very good source of information about what medication suits me and what has worked for me in the past...I may not want to see you and might prefer to see someone else...There really is no point in leaving glossy brochures about forming partnerships and consulting us about anything if you don't really mean it...Please, deeply listen. Show respect and curiosity...It is possible for people with a mental illness to have rich and fulfilling lives...Sometimes you may have to carry my hopefulness for me, just until I get stronger... (Bland, Renouf & Tullgren 2009, pp.159-160).

These studies suggest that clients do not blindly accept what social workers have to offer. The relationship is important to them, respect, acceptance and understanding is important to them, and it is clear that a sense of care is important to them. Pre-conceived ideas and past negative experiences result in clients not always expecting these things from social workers, however when they do exist they are noticed, appreciated and make for a more positive and fruitful experience.

## **The Need for Further Research**

It is evident that greater exploration of care is warranted if the social work profession is to understand how ethic of care theory can inform direct social work practice. Social work scholars can see the value of incorporating care as an ethical stance into social work theory and practice and many social workers 'care' about care. The main dilemma that becomes apparent (Featherstone 2010; Banks 2006, 2008; Parton 2003) is that it remains unclear how care can usefully be applied in everyday social work practice and how it can be carried out in a way that does not undermine a commitment to social justice and human rights. Studies by Gregory (2010), McDonald & Chenoweth (2009), Stanford (2008), Thomas & Davies (2005) and Vonk (1999) have shown that social workers can articulate how they make ethical decisions in their practice based on care – that an ethic of care is already being

implemented if only in an informal way. However, to date empirical studies that have highlighted care have mainly focused on just a few specific fields of practice or other issues which have led to discussions about care. Furthermore there has been minimal research on how social workers conceptualise care and how this informs their practice, and this is in spite of considerable research having been done on this topic in the nursing profession.

An exploration of the literature and research shows that caring elements of a social work interaction are highly valued by social work clients. A definite gap exists in that clients have not been specifically asked about 'care' as a concept in its own right, what it means to them, and what it looks like in their interactions with social workers. I was curious about this omission and wondered if it was simply due to researchers primarily being interested in other related ideas, the difficulty involved in conceptualising care, and/or a fear that the term lacks scientific rigour. I considered that it was necessary to understand and consider an ethic of care that specifically relates to social work practice by gaining an understanding of how social workers and social work clients already understand, enact and experience care (or non-care) in concrete every-day direct practice experiences. This would elucidate practice theory about care in social work. Consequently, the main research question that was formulated after studying the literature was: *How does thinking about, doing and experiencing care in direct social work practice inform an ethic of care in the professional context?*

To answer this main question the following three sub-questions were considered:

1. How important is the concept of care to interactions between social workers and clients in the contemporary context?
2. What enables and/or hinders care in direct social work practice?
3. What are the differences between social workers' and clients' perceptions of caring social work practice in the contemporary context (if any)?

The aim of this research was to add a new dimension to considerations of care by gaining insight into how care is considered, enacted and experienced in concrete ways by studying on-the-ground direct social work practice.

## **Concluding Comments to the Chapter**

In this chapter I have presented concerns raised in the literature about the impact of New Public Management and neoliberalism on caring social work practice.

Suggestions for an ethic of care for social work practice have been highlighted, along with concerns and criticisms about its relevance. The small amount of empirical research conducted to date with social workers and social work clients on this topic has been presented and discussed. My research informs and adds to arguments about ethic of care theory as it applies to social work practice by filling the gap between an abstract knowledge of care and concrete ways that care is enacted and experienced in practice. I maintain that it is timely and crucial to continue empirical research that links practices and experiences of care in social work practice to theoretical ideas around care. This is particularly the case in light of the difficulties the social work profession is facing in the current neoliberal and highly managed context, a context that does not explicitly support caring values. The following chapter presents the theoretical framework that was used for developing the methodological focus of the study and the methods that were used for data collection and analysis.

# Chapter 4: Methodology and Methods

Not everything that can be counted counts, and not everything that counts can be counted (Cameron 1963, p. 13).

## Introduction to the Chapter

In the previous chapter I identified that an ethic of care exists predominantly as an abstract notion in social work practice. While ethic of care theory has received considerable attention in ethical discussions about social work practice, its actual form and meaning remain oblique (Featherstone 2010; Banks 2008; Parton 2003). Very little is known in empirical terms about how an ethic of care is actually enacted by practitioners, nor is it known how care is experienced by social work clients. Much has been said in social work literature about how neoliberal welfare regimes have undermined care. Care, it seems, has become costly (Webb 2006; Bauman 2000). Care has been replaced by a mentality of conditionality (Gray 2010; McDonald & Marston 2006). I have argued thus far in this thesis that as social work is a ‘caring profession’ it is important to more deeply understand how care happens in direct social work practice. This research aimed to bridge the gap between abstract notions of care and concrete understandings of how care is perceived, enacted and experienced in direct social work practice. Accordingly, my research sought to answer the question: *How does thinking about, doing and experiencing care in direct social work practice inform an ethic of care for the profession?* In order to achieve the aims of research I needed to adopt a methodological approach that could enable an in-depth exploration of care as it is enacted and experienced in direct social work practice. In this chapter I explain the theoretical framework of the research and the research methods used in data collection and data analysis.

The chapter is divided into two main parts. The first part of the chapter presents the theoretical framework of the study, explaining how and why a social constructionist theoretical approach and constructivist grounded theory, based on the work of Charmaz (2006), formed the basis of the research. Constructionist theory was

appropriate to situating an ethic of care as a discursive construct in the study, comprising fluid meanings that are context dependent. Through this lens, action and experience became central to ascribing meaning to an ethic of care, and in this way social constructionism enabled a more embodied exploration of the meaning of care in practice. I then explain how Tronto's (1993) ethic of care theory informed the design and implementation of the research.

The process of data collection is described in detail, including the sampling and recruitment strategies that were used and a detailed account of the in-depth interviews that were conducted. The general ethical procedures and considerations of this study are then described. Finally, I outline the process of data analysis that involved the application of a constructivist grounded theory approach.

## **Methodology**

This section addresses the qualitative research methodology used for this research and explains how social constructionism, constructivist grounded theory and feminist ethic of care theory informed this qualitative study. First, I discuss my rationale for employing a qualitative approach.

### **Qualitative research**

A qualitative approach was required to address the purpose and aims of this study. Qualitative research 'refers to any type of research that produces findings not arrived at by statistical procedures or other means of quantification' (Strauss & Corbin 1998, p. 11). As Creswell (1998, p. 17) points out, a research question that asks 'how' or 'what' lends itself to qualitative research whereas quantitative research is more appropriate when a research question asks 'why'? This research asks 'how' care is thought about, enacted and experienced in direct social work practice.

Qualitative methods are inductive and seek to discover or create theories instead of testing them (Padgett 1998, p. 2). This approach to research is useful when little is known about a topic (Padgett 1998, p. 7). Only a very limited amount of research

has been conducted that has explored ideas about care in relation to social work practice. Therefore, in-depth data was required to establish how care is considered and enacted in the concrete world of direct social work practice, providing a window through which to view the lived experience of social workers and social work clients. I decided that engaging in dialogue with the key players in social work interactions would prove to be a meaningful way of understanding care in practice. This study required a design that would elicit rich, in-depth data that would inform an ethic of care for direct social work practice and assist in developing a practice theory for direct social work practice. I explain and discuss the methodological approach that informed the design of the research: social constructionist theory, constructivist grounded theory and ethic of care theory.

### **Theoretical approach to the study**

A feminist social constructionist methodological framework was chosen for this research after first considering a phenomenological approach. Phenomenological research requires an in-depth exploration of the meanings people construct and attribute to lived experiences (Starks & Trinidad 2007, p. 1373). However, I acknowledged that my aim was not to simply focus on the meaning of care but how it is enacted in direct social work practice. Additionally, a phenomenological approach generally focuses on the embodied experience of the individual. It does not consider how certain phenomena are socially constructed. Care by its very nature occurs through interaction with others.

Feminist theorists and ideas have largely informed the body of knowledge on the topic of care, as is evident in Chapter 2. For the purpose of this research it was the constructionist arguments that are embedded in the work of feminist ethic of care theorists (Tronto 2013, 1993; Sevenhuijsen 2003; Graham 2002) who have moved away from essentialist ideas about care, that I found most relevant for studying care in direct social work practice. I wanted to remain open to new and different ways of understanding how care is understood and enacted within the unique context of direct social work practice.

It became evident that constructivist grounded theory, an approach that is underpinned by social constructionist theory, would best answer the research question and inform the design of this study. Viewing this research through a social constructionist lens enabled me to remain open to different ways of thinking about how care is conceptualised, enacted and experienced in social work practice. I now present an overview of social constructionist theory and explain how it informed my research design.

### *Social constructionist theory*

As stated in Chapter 1 social constructionist theory claims that there are multiple ways of understanding and interpreting the world, rather than there being one objective reality or single truth (Andrews 2012; Berger & Luckman 1967). Gergen (2009, p. 167) notes that the most heated criticism of social constructionism is that it seems to be an ‘anything goes’ approach that ‘tolerates everything and stands for nothing’, rendering it a form of moral nihilism. Social constructionism does not necessarily deny holding an ethical standpoint. It claims that such views are socially constructed, and as such, require reflection and being open to challenge (Gergen 2009; Parton 2003). Gergen (2009, p. 170) explains that rules and regulations only become important when people hold strongly to different ideas of what constitutes truth. Instead of promoting traditional ethical values of ‘right’ and ‘wrong’, social constructionists endorse the idea of achieving harmony through interaction and dialogue (Gergen 2009, p. 170). Such harmony may be achieved after understanding that there may not be a single ‘right’ or ‘wrong’ way, but instead a way that works, a way that reduces suffering and increases satisfaction for all (Gergen 2009, p. 170). Gergen’s (2009) standpoint supports the exploration of multiple truths that social workers and social work clients hold in regard to care rather than aiming to discover absolute truth or to test existing knowledge and ethic of care theory. If I had chosen to take a more positivist approach I may have been able to ascertain whether care in direct social work practice corresponds with current ethic of care theory. However, the aim of this research was to allow for new ideas and ways of practising care to emerge, contributing to discussions about the relevance of care in the social work profession and to inform future practice.

Applying a social constructionist lens to this research required looking critically at the concept of care, to question assumptions that underpin theories of care. As Jorgensen and Phillips (2002, p. 176) argue ‘social constructionist research inevitably is, and *should* be, a critical enterprise’. A critique from a social constructionist perspective can be defined as ‘the unmasking of dominant, taken-for-granted understandings of reality’ (Jorgensen & Phillips 2002, p. 176). A social constructionist approach enabled me to remain open and sensitive to multiple claims to truth. Conducting this study through a social constructionist lens enabled the research question to be answered in a way that captured the varied ‘lived experiences’ and views of the social workers and the clients themselves. This approach would allow for subtle, yet powerful nuances to become evident in the data, providing an in-depth explanation of how care operates in social work practice from the perspective of the participants. Social constructionism supports qualitative research approaches that explore ‘lived experience’ accounts of individuals living a certain experience, arguing that they assist in creating shared meaning and understandings of phenomena (Charmaz 2006, Berger & Luckman 1991).

It is important to highlight that social constructionism was not used as an analytic frame for interrogating data. It was used as a conceptual lens for destabilising essentialised understandings of care. After deciding to conduct a qualitative study, I needed to select a specific methodological approach that would both complement the social constructionist paradigm and best answer the research question. The approach I adopted for the research was constructivist grounded theory.

### *Constructivist grounded theory*

Charmaz’s (2006) constructivist grounded theory is congruent with, and complementary to, both the social constructionist stance and qualitative approach that informs this research. Grounded theory methodology was first developed by Glaser and Strauss (1967). They challenged critiques that qualitative analysis was unsystematic, biased, and merely anecdotal, arguing instead that qualitative analysis contained its own form of logic and could be conducted in a systematic way to generate theory (Charmaz 2006). Glaser and Strauss applied a positivist stance in their research, contending that with rigorous application to grounded theory methods the ‘truth’ of a topic or issue could be revealed (Birks & Mills 2011, p. 6).



Charmaz (2006, p. 146) follows much of Strauss and Corbin's original theory. She supports the idea that grounded theory requires developing theories from research data rather than testing hypotheses based on existing theories, while simultaneously grounding the theory in empirical observations or data (Glaser & Strauss 1967). In this research my intention was to develop a practice theory of an ethic of care for direct social work practice. This theory needed to be grounded in the empirical data provided by the social workers and social work clients who participated in this research. Charmaz (2006) follows many of the classical guidelines for data collection and analysis, including theoretical sampling, rigorous data coding techniques, constant comparison of the data and memo writing (Charmaz 2006; Glaser 1978; Glaser & Strauss 1967). Theoretical sampling involves 'identifying and pursuing clues that arise during analysis in a grounded theory study' (Birks & Mills 2011, p. 69). This generally requires researchers to recruit new participants or conduct second interviews with existing participants in order to attend to theoretical concerns or gaps that become evident during the analysis (Charmaz 2006, p. 101). Data coding techniques include initial, focused and axial coding with each form of coding progressing towards a more abstract and conceptual analysis of the data (Charmaz 2006; Glaser & Strauss 1967).

The method of constant comparison is one of the main concepts that distinguishes grounded theory from other interpretive research designs (Birks & Mills 2011, p. 11). It promotes analysis that remains fluid, interactive and open-ended (Charmaz 2006, p. 178) and results in the construction of an abstract conceptual framework that is rich in meaning, rather than merely a qualitative descriptive account (Birks & Mills 2011, p. 94). Memo-writing involves continually stopping and analysing ideas about codes and emerging themes by writing down whatever ideas and thoughts that occur throughout the data analysis process (Charmaz 2006, p. 188). I determined that Charmaz's theory would inform the research methodology of this study, and discuss how I attended to each of the components of her approach in the second section of this chapter, titled 'Data collection and data analysis'.

Charmaz (2006) diverts from the standpoint that data provides evidence of truth. Instead, she argues that theory development is always co-constructed by both the participant and the researcher based on past and current knowledge and interactions

with people, views and practices. Constructivist grounded theory takes a middle ground between realist and postmodern perspectives. It is realist in the sense that it attempts to present 'reality' as perceived and presented by the participants, but acknowledges that it is only ever a partial representation of experience and can only produce limited, tentative generalisations, and not universal statements (Bryant & Charmaz, 2007, p. 52). I was aware early on while reviewing the literature that there was likely to be a range of ways that care was conceived and enacted in direct social work practice. Charmaz's (2006) approach demands awareness that theory depends on the researcher's view and as such required me to take a reflexive stance in considering how my own views, values and background may impact on the analysis in order to minimise the influence these had on analysis and the theory I would develop. A constructivist approach to grounded theory places a particular focus on how and why participants construct meanings and actions in certain contexts, and this focus aligns with the aims of this study, which were to explore the meanings and actions social workers and clients attributed to caring direct social work practice.

Strauss and Glaser's (1967, p. 37) early work on grounded theory discouraged using existing literature to inform research, arguing that it interfered with the inductive approach of grounded theory and could potentially 'contaminate' data analysis. Strauss and Corbin (1998, p. 49) later acknowledged the value of studying literature, arguing that it enhances sensitivity to subtle nuances in the data and can assist in formulating questions during the analysis process. A reasonable understanding of the literature can be useful, provided the 'researcher does not become so steeped in the literature that he or she is constrained and even stifled by it' (Strauss & Corbin 1998, p. 49). Wiener (2007, pp. 298-299) criticises the classical view that the literature should not be reviewed until the theory seems sufficiently grounded and developed, stating:

On the contrary...both the academic and the popular press were replete with articles that were useful to us from the very beginning our research. If anything, remaining current was the pressing challenge. Unquestionably, these articles widened our horizons and enriched our interviews.

Charmaz (2006) supports Strauss and Corbin's (1998) conservative approach, arguing that it is important to maintain some balance between allowing the literature to inform research and allowing the literature to force the findings. For the purpose

of this research, it was necessary to conduct a thorough literature review in order to meet the university's requirements for the research proposal. Knowledge of pre-existing theory and studies on an ethic of care assisted me to design the research and interview questions. The literature helped me notice subtleties in the data and think about concepts in different ways. At the same time, I acknowledged that it was important that my research question allowed for new knowledge and different interpretations of caring practice to emerge that were not present in the literature. I attempted to put my knowledge of the literature aside as much as possible while conducting the research. I remained alert to new themes and ideas and re-engaged with the literature to explore these only after the data was collected and the analysis was well underway.

Like any research methodology, grounded theory has its limitations. Charmaz (2006) addresses many of the criticisms of the classical approach. She argues that interpretive research cannot 'discover' truths. She acknowledges that grounded theory research cannot be purely inductive because prior knowledge, views and values are always brought into the research process and are often necessary in order to identify and interpret emerging concepts. Charmaz (2006) argues that building a theory is a subjective process. She offers ways of minimising subjectivity while at the same time accepting that it is inevitable to some extent when interpreting complex, abstract concepts. Bryant and Charmaz (2007, p. 52) contend that 'The researcher becomes an interpreter of the scene, not an ultimate authority defining it'. In this research the interviews merely 'provide the site for active interactions between two people leading to results that are both mutually negotiated and contextual' (Mills, Bonner & Francis 2006, p. 9). It was evident when conducting my research that care was perceived in a myriad of ways and I wanted to explore these different interpretations. It was my intention to identify a general narrative of care in practice, based on commonalities presented by the participants of this study rather than to 'discover a truth'. As Bryant (2002) argues, the structured, prescriptive guide to grounded theory can lead some researchers to choose it over other methods, simply because it is easy to follow. I have provided my rationales for choosing this approach over others, such as phenomenology and feminist methodology. While it may be quite structured, constructivist grounded theory is also complex and time-consuming and requires continual reflexivity. Constructivist

grounded theory was chosen because it was the most appropriate methodological approach for this research and because it supported my commitment to conducting the research from an ethic of care perspective, which I discuss in the following section of the chapter.

### *Employing an ethic of care throughout the research process*

Existing feminist ethic of care theory played a significant role in informing the ethical considerations of this study. My research is about an ethic of care, and the knowledge I gained from reading about this ethical theory highlighted the importance of incorporating it into my methodology and research design. As Haverkamp (2005, p. 147) argues, ticking off boxes on an ethics application is not sufficient ethical practice in research. In order to ensure the research was ethical, individual decisions, actions and relationships needed to be considered. Qualitative research by nature involves a relationship between the researcher and participant (Haverkamp 2005, p. 150). Tronto's (1993, pp. 127-137) five ethical dimensions of care, as outlined in Chapter 2, informed the planning, implementation and analysis of my study, that is, attentiveness, responsibility, competence, responsiveness and integrity. I explain how each of the dimensions of care related to the context of the research process for this study.

#### *Attentiveness*

Attentiveness refers to the need to recognise and remain aware of the needs of the other (Tronto 1993, p.127). Being attentive in my research meant that I ensured that participants understood and felt comfortable with all aspects of the research process. It required me to be as certain as possible that the information sent to participants was understood and that consent was informed. I demonstrated attentiveness by continually listening to participants, and picking up on cues that required further questioning. Remaining attentive enabled me to notice the often subtle differences between the way that care was described, enacted and experienced by social workers and social work clients. I was able to draw on these differences to question participants more thoroughly during interviews.

#### *Responsibility*

From an ethic of care perspective Tronto (1993, p. 132) argues that responsibility is a core moral concept that moves beyond formal or legal requirements that ethical

agents are obliged to uphold. She describes the responsibility to care as an end in itself, motivated by the inclination to care, and driven by the needs of the other (1993, p. 132). I remained mindful of this responsibility to care throughout the research process and accepted that there were times when the interests of the participants needed to be given precedence over the interest of my research. As Haverkamp (2005, p. 149) argues, decisions must take into account the unique context an issue is situated in. The importance of considering context when taking on the responsibility to care was highlighted to me in an article published by McAuliffe and Coleman (1999). While observing homeless people who spent most nights camped in a city park, Coleman recognised a dilemma. While the park was technically a public space, it was also the 'home' of the people she was observing; Coleman felt a sense of responsibility to avoid intruding on their private space. By deciding to inform the homeless people of the times she would be observing them, and seeking their approval, she was able to ease the ethical tensions that existed between conducting valid research and showing respect for the homeless people in the park, which was also their home (McAuliffe & Coleman 1999, p. 31). Although the authors of this article do not speak specifically about an ethic of care, it is reflected in their research practice.

An example of demonstrating the ethical dimension of responsibility in my own research involved a client who did not want to have their interview recorded. Although an information sheet had been provided prior to the interview that clearly stated that the interview would be recorded, I respected the participant's request not to record their interview. I needed to make a decision whether to continue with the interview given that I would not have a full transcript to work with. The best I could do was to take a few notes and write up as much as I could remember after the interview. I wanted to listen deeply to the story that I was told, and therefore I could not write frantically throughout the interview. It became apparent that the participant struggled with trusting professionals due to negative past experiences. I felt privileged that this person was prepared to trust me at all and I thought that it was important to allow him to tell his story. I included the interview in my data set. I was aware of my responsibility to address the needs for anonymity of participants. Two social workers and one client returned transcripts to me requesting that I delete portions of their transcripts. The client returned the transcript twice before being

satisfied that there was no identifying information contained in it. This meant that some poignant practice examples and valuable quotes could not be considered in my analysis or reported in my findings chapters. These were sacrifices that I was prepared to make. I was aware that ultimately I was likely to gain more from the research process than the participant. I appreciated the generosity demonstrated by the participant, in giving his time and energy and disclosing personal information. The stance that I took was that the least I could do was take some care to ensure the participant was as comfortable as possible, and I did not want to cause any unnecessary distress by challenging these requests. I remained continually aware that I had a responsibility to meet the needs and concerns of the participants, and that this responsibility trumped my own research agenda.

### *Competence*

Tronto (1993, p. 133) refers to competence as a dimension of care that involves drawing on knowledge, skills and abilities to meet caring needs whenever possible. She states: 'Intending to provide care, even accepting responsibility for it, but then failing to provide good care, means that in the end the need for care is not met' (1993, p 133). In this research, competence was demonstrated through practical aspects of the research process. Conducting pilot interviews to determine that interview questions were understood and relevant, safe-guarding participants' information, returning phone calls promptly, arriving at appointments on time and choosing an appropriate methodology and research design all assisted in ensuring that the research was carried out in a competent manner. Regular discussions about the research process during meetings with my research supervisors helped me to ensure that the process was both ethical and rigorous.

### *Responsiveness*

Responsiveness requires putting aside one's own assumptions about what it may be like to be in the other's situation and listening to how others express their position (Tronto 1993, p. 136). In this research, responsiveness involved continually clarifying participants' ideas and explanations of care in social work practice, re-wording questions if I felt they were not properly understood and encouraging participants to thoroughly check transcripts and to make any necessary changes. This minimised the likelihood that my own assumptions would cloud the interpretation of the data. I took care to remain faithful to the participants' voices,

ensuring that they did not become lost in academic language when reporting the findings of the research. As Hughes (2009, p. 107) points out, the researcher may be ‘accountable for the language and concepts communicated in the research, but the stories that participants tell will always remain theirs’.

### *Integrity*

The final dimension of an ethic of care that Tronto (1993, p. 137) highlights is integrity, which requires that attention, responsibility, competence and responsiveness are all integrated into a complete whole. In this research integrity was maintained by questioning how all four of Tronto’s dimensions of an ethic of care were being attended to when making decisions about the research process and considering my responses to dilemmas that I encountered along the way. For example, when analysing the data I would think about whether I was fully paying attention to the participants’ words and stories. I asked: Was I being responsible by considering how every sentence could potentially add something of value towards answering the research question? Did I conduct the analysis in a competent manner by choosing an appropriate data analysis method? Did I apply it in a methodical and thorough way, avoiding short-cuts? Was I responsive to the data and the overall story being told? Was I continually cross-checking meanings of views and experiences across the data set?

The next section of this chapter explains the methods used to collect and analyse the data for this research that addressed the research question. I demonstrate how I remained committed to principles of social constructionist theory, constructivist grounded theory and an ethic of care while carrying out the practical aspects of the research.

## **Data Collection and Data Analysis**

I begin this section by outlining the context of the research and I explain the rationales and steps involved in designing and implementing the data collection process. Sample methods, recruitment strategies, ethical procedures and considerations, and the interview processes are included.

## **The context of the research**

This research was conducted in Tasmania, Australia. The sample includes social workers and social work clients from across the state. Social work practitioners from a wide range of fields of practice and social work clients were invited to participate in the study. An advantage of conducting the research in this community included easy access to social workers and relatively short travel distances. I acknowledge that while recruitment from further afield (nationally) may have produced different results, it would have exceeded the financial and time limits of this research.

## **Sampling**

The sample comprised 15 social workers and 15 social work clients throughout Tasmania. The sample size was sufficient to support an in-depth analysis. As argued by Liamputtong and Ezzy (2005, p. 49), the number of participants in qualitative analysis is less important than the richness of the data. A common expectation of qualitative research is that ‘saturation’ of the data is achieved. Saumure and Given (2008, p. 195) define data saturation as, ‘the point in data collection when no new or relevant information emerges with respect to the newly constructed theory’. Green and Thorogood (2009, p. 120) argue that achieving saturation of all properties and dimensions is a potentially limitless task. This was particularly the case researching a topic such as ‘care’, where there are numerous ways of understanding the concept and how it is enacted. It was not realistic to relentlessly ‘test’ the theory of my research given the limits of time and resources associated with this study.

When deciding on sample methods I was mindful of the need to consider theoretical sampling to build theory from the data. The gradual recruitment of participants, as well as the concurrent nature of data collection and data analysis in my research, allowed me to address these issues as the study progressed. I continually asked myself questions, as suggested by Birks and Mills (2011, p. 69), such as: What is obvious? What seems to be absent? Is there something more obscure going on that has not been fully recognised? I employed different sampling methods for social



workers and social work clients. Below I first explain the sampling methods used for social workers, followed by the sampling methods used for social work clients.

### *Social workers*

Social workers for this research were recruited through purposive and snowballing sampling strategies (Patton 1990). Purposive sampling was chosen as I wished to purposively target social workers from a wide range of practice fields. As stated by Liamputtong and Ezzy (2005) ‘purposive sampling aims to select information-rich cases for in-depth study to examine meanings, interpretations, processes, and theory’. I did not initially plan to use snowball sampling, which involves respondents passing on information about the research to other potential respondents (Liamputtong & Ezzy 2005), however this evolved naturally when two social workers contacted me after speaking with existing participants.

Social workers were required to meet the following criteria in order to participate. Practitioners needed to:

- be aged 18 years or over;
- have at least 12 months experience as a qualified social worker; and
- be eligible for membership of the AASW.

As this research explored care in social work practice, it was crucial that participants were qualified social workers. I was aware that some counsellors and community welfare workers align themselves with social work when in fact they do not have a university degree in social work. While I acknowledged that many of these people have a wide range of experience and are highly competent in their work, for the purpose of the validity of this study, having an accredited social work degree was essential for participation.

### *Social work clients*

Purposive sampling was the primary sampling strategy for clients. Clients who met the following criteria were invited to participate in this research. They:

- were aged 18 years or over;

- had experienced a social work interaction with a qualified social worker during the past 12 months; and
- could speak English.

I did my best to ensure that clients had seen a qualified social worker. I was aware that some people may have mistakenly believed that the counsellor or case-worker they had seen was a social worker. Not all counsellors, welfare workers or case-workers are social workers. In order to mitigate this issue I requested that potential participants check with their agency if they were at all unsure of the qualification of the person they had worked with. If the person was specifically in a social work role or if documents included the letters BSW (Bachelor of Social Work) or AASW (Australian Association of Social Work) next to the person's name, then the client could confidently assume that the person was a qualified social worker. I could have asked clients the names of social workers they had worked with, which would have enabled me to check their qualifications. However, this raised an ethical dilemma for me. I did not feel comfortable with the identities of social workers being revealed without their knowledge, particularly as I was hearing the subjective experiences of the clients. Additionally, I was aware that clients may not have been willing to be as open and honest about their experiences if the social workers were named, in spite of reassurances that information would remain confidential. I therefore chose to trust the judgment of participants. I was aware that there was a possibility that clients may have still incorrectly identified their counsellors as qualified social workers and that this remains a limitation of the study.

I did not seek information about whether the clients had seen social workers in a voluntary or involuntary capacity. I did not want client participants to feel obliged to reveal any information about the specific context or issue that led to their involvement with a social worker if they did not feel comfortable sharing this with me. This was explained to clients in the Information Sheet for Social Work Clients (Appendix 7). It mostly became evident, however as to whether clients had a choice about working with a social worker, and I was able to use this information when interpreting the findings of the study.

My rationale for requesting that participants had seen a social worker during the previous 12 month period was to ensure that their experiences were relatively fresh in their minds and therefore easier to recall. While I did not wish to exclude anyone from this study based on their ability to converse in English, the reality was that the allocated funds for this project did not cover costs for interpreters.

## **Recruitment strategies**

Recruitment strategies for social workers and social work clients varied. I now explain each process separately.

### ***Social workers***

I began the recruiting process for social workers by targeting a small number of potential participants. In order to attend to theoretical sampling it was appropriate to recruit participants in stages, allowing time to type transcripts and begin some initial data analysis before continuing with recruitment. This helped me realise the value in recruiting participants from specific practice settings in order to fill some gaps that were emerging in the data. While I was prepared to request a second interview with some participants, conducting the recruitment and interviews in stages rendered this unnecessary. I mailed 25 copies of the Letters of Invitation to Social Workers (see Appendix 1), the Information Sheets for Social Workers (see Appendix 2) and the Consent Forms for Social Workers (see Appendix 3) to social workers from a broad range of social work agencies and organisations that employed social workers across Tasmania. As I have worked as a social worker in Tasmania and visited many organisations while being employed in the role of a field-work liaison officer with the University of Tasmania, I was familiar with many organisations that employed social workers. I also used Tasmanian regional phone directories to locate organisations. If I was unsure whether organisations employed social workers I telephoned them to check before mailing out information. The names of potential participants were sought by telephoning agencies and organisations. I felt confident that I was familiar enough with the organisations and services in Tasmania that deliver social work to draw on my own knowledge to ensure that I covered a broad range of social work fields of practice. Potential participants were asked to contact me via phone or email if they were interested in participating in the research. Four

social workers contacted me in response to the information that I had sent to agencies and they agreed to participate in the research.

I spoke about my research at an academic forum for social workers at the University of Tasmania and at team meetings at two organisations. Information sheets were provided for those people who were interested in the study. Another three participants were recruited through this strategy. I soon began to hear from other social workers who had spoken to existing participants, resulting in another four social workers being recruited. The recruitment and interviewing of these 11 participants occurred over a period of approximately 12 weeks. I mailed out a further 25 information packs, targeting fields of practice that I had not already recruited from. This mail out resulted in the recruitment of the final four social workers for this study.

As I am a member of a relatively small community of social workers in Tasmania it would have been difficult to avoid interviewing people I knew. While recruiting social workers I remained aware that relationships I had formed through my studies and employment could pose a threat to researcher objectivity, or could result in assumptions being made about their practice. As the majority of my experience as a social worker has been in academic roles, my exposure to the direct practice of social workers was limited. As a researcher I was committed to taking a stance of genuine curiosity, putting aside any assumptions I may have had about practitioners' views or practice, and I assured each participant that my intention was not to judge their ideas or practice. I had not had any discussion about 'caring practice' with any of the social workers who participated. The two social workers who I knew reasonably well had always been honest and transparent about their views when discussing other aspects of their practice with me and were not afraid to challenge any ideas I held that they disagreed with. I therefore felt confident that they would not be tempted to withhold their opinions or be reluctant to share examples of practice. None of the participants were colleagues at the time of participation, close friends or relatives. I had not previously met 8 of the 15 participants.

Of the 15 social workers who participated, 10 were employed in government organisations and five were employed in non-government organisations. Participants

ranged in age from 25 years to 58 years and consisted of 11 females and four males. The number of years of experience as qualified social work practitioners ranged from three to 35 years.

### *Social work clients*

Recruitment of clients proved to be more difficult and occurred over a period of about eight months. Although this was a slow process I considered it necessary to be patient in order to meet ethical requirements. I deemed it unethical to directly recruit clients through social workers. Clients may have possibly felt coerced into participating due to the power imbalance that inevitably exists between social workers and clients. Conversely, social workers may have been hesitant to pass on information to clients who did not seem satisfied with the service provided or if the social worker/client relationship appeared to be tenuous.

The first recruitment strategy involved distributing copies of the Flyers for Client Recruitment (see Appendix 4) to a variety of social work agencies, as well as libraries and community health centres throughout Tasmania, that were displayed on notice boards. All but one organisation agreed to display the flyers: it was explained to me that it was against organisational policy to do so.

In recognition of the time and energy spent on participation, clients were offered a \$50 Coles/Myer gift voucher. Participants were very appreciative of this token of appreciation and it provided a strong incentive for some. Unfortunately the Faculty budget did not allow for the same offer to be made to the social workers who participated. The decision to reward the client participants with the vouchers instead of the social workers was based on the assumption that social workers would likely view participation as a valuable opportunity to contribute to the field of research as well as provided a chance to reflect on their practice. This was confirmed by many participants who made comments such as ‘This has been a wonderful opportunity to reflect on what I do and why I do what I do’.

I conducted a second recruitment strategy that involved approaching managers from organisations that employed social workers. To begin, I sent a copy of the Letter to Agencies Seeking Recruitment Support (see Appendix 5) to the managers of three

state-wide organisations. I then followed up this process by making phone contact with the managers of these organisations, all of whom raised ethical issues about mailing information to clients. Two of the organisations had a policy in place, stipulating that clients would not be posted any information that was not directly related to service delivery and consented to by the client. The manager from the other organisation did not believe it was ethical to assist with recruitment without the involvement and consent of the social workers the clients had worked with. As I had my own ethical concerns around directly involving social workers in the recruitment process I decided to forego this strategy in the hope that I would be successful in recruiting a sufficient number of participants through the displayed flyers. I did consider advertising for participants in Tasmanian newspapers. This would not have been a straight forward process, however. University policy required that I employ media staff to prepare advertisements that met specific standards. This would have been an expensive exercise that was beyond the scope of my allocated budget. Fortunately, the flyer strategy proved to be successful.

Potential participants contacted me by phone. I spent a few minutes expanding on the information provided in the flyers and clarifying that the person had indeed seen a social worker. If the person was still interested in participating I explained that I would post or email him or her a Letter of Invitation to Social Work Clients (see Appendix 6), an Information Sheet for Social Work Clients (see Appendix 7) and a Consent Form for Social Work Clients (see Appendix 8), and I requested that he or she read through these before making a final decision to commit to participating in the study. I arranged to contact them again in a few days to organise an interview if they remained happy to proceed with participation. All contacts resulted in an interview with no-one changing their mind after the initial contact.

In total I recruited 15 client participants. Their age range was from 21 years to 72 years and consisted of seven females and eight males. While the flyer and information sheet stipulated that participants must have seen a social worker during the previous 12 month period, it soon became apparent that some participants had many stories to tell, some of which went back several years. Participants had clear memories of these experiences that provided me with valuable data. I decided that it was important to allow these stories to be told and to include them in the analysis. In

hindsight some of these accounts may hold even more meaning, simply because clear memories had endured over time. A range of ethical issues also needed to be considered throughout the research process, which are discussed in the following section.

## **Ethical considerations and procedures**

In this section I explain the ethical procedures that were considered before beginning the research. These are an adjunct to and complement the ethic of care framework that I have outlined in the methodology section of this chapter. Approval for this study was granted from the University of Tasmania's Social Sciences Human Research Ethics Committee on 6<sup>th</sup> July 2011. The ethical principles addressed in the ethics application centred on the four main issues: informed consent, confidentiality, anonymity and protection from harm. I explain below how I addressed each of these issues in turn.

### ***Informed consent***

The principle of informed consent requires that participants understand what is involved in the research process and that they voluntarily agree to participate without coercion from the researcher or any other person assisting in the recruitment process (Israel & Hay 2006, p. 61). To ensure this occurred, I mailed each potential participant an Information Sheet and Consent Form that clearly explained the participation process. This allowed time for people to read about and reflect on their potential involvement as participants. I then spoke to each person who expressed an interest in participating, checking that they had read the information provided and invited any questions they may have had about the process and the study in general. I stressed that participation was entirely voluntary and there was no obligation to go ahead with interviews if participants were hesitant in any way. I decided not to directly phone or approach individual social workers in spite of knowing many of the social workers in Tasmania. By posting the information I created distance between potential participants and myself, aiming to ensure that participants were less likely to feel obliged to participate than if I were to phone or visit them. I chose not to follow up the mail-outs as I was conscious that I did not want social workers to feel coerced into participation.

While recruiting client participants directly through their social workers would have been a fairly easy and time effective strategy I decided not to do this as it may have resulted in clients feeling coerced into participation. Instead, I placed flyers in social work agencies. This strategy reduced any form of coercion to participate from either myself, or organisations attended by the clients. Clients were requested to contact me directly if they were interested, which meant that the agency did not know who had decided to express their interest in the study.

### *Confidentiality and anonymity*

The principle of confidentiality is concerned with ensuring that the information provided by participants remains private and is used only for specific purposes by the researcher (Israel & Hay 2006, p. 77). To ensure this privacy, I conducted all of the data collection and transcribing of interviews without any assistance from any other person. When transcribing interviews I used ear-phones if anyone else was in my shared office at the University and when I was at home when another person was in the house. Both my computer at the University and my personal lap-top computer required a password to gain access to computer files, which minimised the chance of anyone else accessing the data. Hard copies of the interview transcriptions were kept in a locked filing cabinet in my University office.

Anonymity is closely aligned to confidentiality as it too concerns matters of privacy. Anonymity relates to concerns that participants may be identifiable in the research. In order to minimise the possibility of participants being identifiable I did not use their real names when transcribing interviews and when presenting participants' views in this thesis. Instead I requested that they provide me with a pseudonym to use. I was careful to collect limited demographic information, omitting details of organisations associated with the social workers and the clients who participated in my study. Due to the small size of the social work community I considered it was important to be cautious about providing potentially identifying information to readers of this thesis, and readers of articles that may be published from this research. In this thesis I chose not to name the geographical locations of participants, their cultural backgrounds, nor the specific fields of practice or organisations they practised in or visited. I was already concerned that the gender of participants, years of experience, practice examples provided, and 'turns of phrase'



in quotes used may have provided clues of participants' identities. I did not want to add to the risk of participants being identified by narrowing the possibilities further. As the focus of the study was on generic direct practice, not specific fields of practice, the caution I applied to protect anonymity did not detract from the findings and conclusions of this study.

I highlighted to participants the risk of being identified and I asked them to be mindful of this issue when they were checking transcripts. I encouraged them to particularly consider specific practice examples they may have provided in their interview, such as examples that might identify the participants' workplace. Finally, I was especially mindful of identifying information that may have been used when I was choosing quotes to illustrate themes. For example, on occasion client participants used the first name of their social worker, or the organisation they had visited; this information was omitted from transcripts. A limit to confidentiality was that participants' accounts would be used in reporting the findings of the research in the dissertation and might be published in articles. These limitations were explained to participants.

### *Protection from harm*

The final ethical consideration of my research relates to the principle of non-maleficence which concerns the minimisation of risks of physical and emotional harm or discomfort to participants (Israel & Hay 2006, p. 95). I recognised that discussing care in social work interactions has significance for both social workers and clients and I was cognisant that discussing care could possibly evoke participants' strong emotions. Social workers were asked questions which involved discussing specific aspects of their professional practice which they may not normally have divulged to others. This could have created some apprehension and anxiety due to their fear that I would judge them. Reflection on practice may have resulted in social workers questioning their own skills, knowledge and use of self, and this could have caused them some discomfort. To address these concerns I assured participants that my intent was not to judge their practice and that I was simply interested in their views about care and the way they put it into practice. While I acknowledge that it is very difficult to suspend all judgment when listening to the views of others, I was committed to suspending such judgment as much as

possible. It was important to also consider that judgment is not always negative. When speaking to client participants I made it clear that it was not necessary to divulge details about the nature of the issue that led them to see a social worker. Some participants still chose to do so, however I was mindful that it was possible that by revisiting their experiences they may have experienced some apprehension and anxiety. Therefore, I explained that they were under no obligation to discuss anything that felt too personal or private to them.

I was aware that social workers and clients could have become distressed when talking about their experiences of a social work intervention, particularly if the issues which brought about the intervention were especially sensitive. In the case of social workers, talking about care may have raised questions and uncertainties in their own minds about their practice which could have been confronting. While such reflection is an important part of practice, and participation in this study provided a valuable opportunity for social workers to engage in reflection, it was also important that I remained sensitive to possible distress that the process evoked. For clients, speaking about a social work interaction may have refreshed memories of difficult times in their lives or an unpleasant experience with a social worker. In view of these risks, and to help people feel more comfortable, I explained to participants that they could stop the interview at any time and have a break; they could ask to continue the conversation at another time or they could completely withdraw from the study. This information was also included in the Information Sheet. Participants were assured that their request would be respected and that there would be no consequences for them if they decided to terminate their participation. I discussed what they would like me to do if they did become distressed. As a social worker I felt confident that I would be able to respond appropriately to anxiety and distress that may have arisen. Contact details of free counselling services were made available to participants in the event that anxiety or distress did occur, and they were encouraged to make use of these services if necessary. Once satisfied that ethical issues had been attended to, I moved on to conducting the interviews for this research, which I explain in the next section of this chapter.

## **The interviews**

In-depth, semi-structured interviews were chosen as the method for collecting data for this study. In-depth interviews were conducted in order to gain an understanding of the 'lived experience' of care for both social workers and clients. The purpose of these in-depth interviews was to gain a holistic understanding from the perspective of the participants so that I could make recommendations for social work practice and further research. I was not attempting to test hypotheses or simply answer questions (Seidman 2006, p. 9). Using in-depth interviews allowed for potentially important ideas to emerge that may not have been raised in a questionnaire or a structured interview.

A semi-structured approach allowed me to conduct in-depth interviews while being guided by several open questions. I thought it was important to have some structure to the interviews as care is a relatively abstract concept. Participants were strongly encouraged to raise other ideas that they found salient to the discussion, which served to enrich the data.

I was aware that the value of interviewing was highly dependent on my ability to communicate in an effective way that allowed participants to freely share their views and to tell their stories without feeling restricted (Clough & Nutbrown, 2007, p. 134). I believe that my skills as a social worker, along with my commitment to applying an ethic of care throughout the research process assisted this to happen. This involved using open questions, listening attentively, interrupting only when absolutely necessary, and using pauses, prompts and probes appropriately to elicit more information. Interpersonal skills such as maintaining genuineness, making small-talk, inclusion of appropriate humour and employing humility and empathy helped me to develop rapport with participants (Opie 2004).

Interviews ran for an average of one hour and 30 minutes. I did not have a strict time limit. Some interviews were shorter than the average, while others were closer to two hours. Interviews were recorded with the participants' permission, using a digital recorder, with the exception of one client participant who stated that he would prefer not to have the interview recorded. I respected this request and took notes

instead. Some participants were initially slightly anxious about their interviews; they expressed concern that they might not have much to offer on the topic of care. I reassured them that whatever they had to say would be appreciated. All participants soon began to speak freely and passionately about the topic. The carefully considered questions seemed to assist deep and free flowing discussion and enabled strong views to emerge.

I found that participants began to discuss their experiences of care during my initial phone call with them or at the interview before I had the chance to turn on the recorder. The sharing of experiences would also often continue after I had turned off the recorder. After the first couple of interviews, I kept a pen and paper close by, so that I could write down comments during the phone call, and later I asked permission to include these notes in the data. I started to seek permission to turn the recorder on at the first possible opportunity, that is, before the interview formally began.

### *The interview schedules*

Separate interview schedules were developed for social workers and clients. The schedules were trialled with a pilot interview with a social worker and social work client before beginning the formal interviews. I discuss this process in more depth in the next section of this chapter. I began each interview by exploring the meaning all participants attributed to care, followed by asking their views about the relevance of care in practice. It was important to establish meaning before considering how care was enacted and experienced as there is no single definition of the term 'care'. As McBeath and Webb (1997 p. 45) highlight, 'Care is an elusive concept...the word care tends to appear by default independent of any consideration of what it may mean'. Subsequent questions in the interview schedules for both social workers and clients focused on practice examples of care and personal qualities that indicated care. Social workers were also questioned about any difficulties they faced implementing care in their practice. The questions that guided the interviews with social workers can be viewed in the Interview Schedule for Social Workers (see Appendix 9). The questions that guided the interviews with social work clients can be viewed in the Interview Schedule for Social Work Clients (see Appendix 10).

The interview schedules were modified to some degree as the interviews progressed based on new insights provided by the participants. The first question on the social workers interview schedule was ‘What does the concept of care in relation to your practice mean to you?’. It became clear after the first interviews that social workers talked about care in two main ways: as practical action and/or as a feeling towards their client. During the early interviews, social workers often spoke about the difficulties they faced maintaining caring practice when organisational policies were not aligned with such practice. Several social workers also mentioned the problems a neoliberal world view posed to their practice of care. I wanted to explore these emerging topics further, and as a result I decided to ask the following questions in subsequent interviews:

- Some people talk about care as a feeling towards another and others more as action. What are your thoughts about this?
- Have you experienced any conflict between your ideas of caring practice and organisation policies and standards?
- The neoliberal world view places value on individualism and self-responsibility. How does this view impact on how you think about and practise care as a social worker?

Insights emerged from the early interviews with social work clients. Clients spoke in similar ways to social workers about care being an attitude, practical assistance, or both. They indicated that the type of care they expected from a social worker was quite different to the type of care they expected from family and friends. In order to explore these ideas further, I added the following questions to subsequent interviews with social work clients:

- Do you see care as an attitude towards you, more about practical assistance, or both? Can you give me some examples?
- Is there a difference in the way you expect a social worker to care, compared to a friend or family member? What might this difference be?

Throughout the interviews I continually asked questions to elicit more information and clarify responses. Examples of such questions were: ‘Can you tell me more about that?’, ‘What happened next?’, and ‘So, when you say you are there for the client how do they know that?’. At the end of each interview I checked whether there

was anything that participants considered to be relevant to the research that I may not have considered. It was important that my participants felt that they had gained something valuable from their interview, even if that was just the chance to share their views and experiences of care within the social work context.

### *Pilot interviews*

I conducted two pilot interviews before commencing formal data collections. These were conducted with a social worker who I knew and a friend who had experienced a social work interaction as a client. While I knew both participants I was not aware of their views and experiences of ‘care’ in social work practice before speaking with them. The purpose of these interviews was primarily to confirm that the planned interview questions would produce rich data relevant to my research question. I also wanted to ensure that the interview flowed as an engaging conversation. It was important to clarify that the questions and language used were understandable, and that the estimated time put aside for interviews was realistic.

Feedback about the relevance and suitability of questions was sought, as well as how I had conducted these interviews. I requested that both participants be honest with their feedback, assuring them that although we knew each other quite well I welcomed their constructive criticism. Both participants said that they enjoyed the interview process and valued the experience to speak about care in social work practice. While they had not really consciously thought about this topic before, they realised that there was plenty to say and felt that the questions assisted them to think about and express their views. Both of the pilot participants confirmed that they did not find the questions to be leading and they did not really know what I might have expected to hear. After completing these interviews I was satisfied with the interview schedules and the general plan; I felt ready to go ahead with the first formal interview. I reflected on whether the data from these pilot interviews would assist in answering the research question of this study, and felt confident that it would.

### *The interview process – social workers*

The location of interviews was negotiated with the social workers who participated. Interviews were conducted in either participant’s workplaces, at the Launceston campus of the University of Tasmania or in participants’ homes. Choices were

dependent on each participant's personal preference. I did not have any concerns about my own safety when visiting social workers homes as I either knew or knew of most of the participants. I felt confident that as social workers who would have undergone police and character checks throughout their career that they would not be likely to pose any risk to my safety. I was aware that social workers may not have been comfortable with me knowing their private addresses, which was another reason why it was important that participants choose the location of interviews. Time was taken with each person to catch up if we already knew one another or to get to know each other a little if we had not met before. As the Tasmanian social work community is relatively small, I did know several of the social workers who participated in the research, either through my work in the field or as a result of my work as a social work educator and field liaison officer.

I checked that people had read the Information Sheet and I answered any questions they had prior to beginning their interviews. I reiterated the anonymity aspects of the process. I ensured that participants understood that they would have the opportunity to view their transcripts and change or delete anything they were not comfortable with being included. This allowed for participants to speak freely without worrying that they were saying anything that they may later regret. A Consent Form was then given to each participant. They were asked to read the form carefully and to sign it if they were satisfied. They were also asked to indicate if they would like a copy of findings from the research. Interviews did not commence until I was confident that all of this information was understood and that participants were comfortable to go ahead with the interview.

### *The interview process – social work clients*

The location of interviews was negotiated with social work client participants. One participant chose to be interviewed in a private room at the University of Tasmania, Launceston campus. All others were interviewed in their own homes. I did not know any of these people prior to the interviews. I was somewhat hesitant about visiting people whom I did not know in their homes, although I was aware that participants would likely feel more comfortable talking to me in their own environment and that it would also be more convenient for most of them. I took measures to reduce any threat to my safety. These included carrying my mobile

phone at all times, assessing my level of comfort when speaking to people on the phone prior to the interviews, notifying my supervisor of my intended whereabouts prior to the interviews and planning an excuse to leave quickly if necessary. In one instance I did feel slightly uncomfortable, as a participant locked all the doors and avoided making eye contact with me when I began speaking. It soon became apparent that this person was suffering with a mental health issue and was simply conscious of his own safety. I was able to quickly assess the situation and realise that my own safety was not at risk. However, this experience did provide me with more insight into the potential risk of placing myself in a vulnerable situation. On reflection, conducting interviews in a place where other people were close by, such as a community health centre would have posed less risk to my safety. As this was the second last client interview and I already had another interview scheduled for later that day I did not change the location for the final interview. However, I would have organised another location for subsequent interviews if this situation had occurred earlier in the process.

Through speaking to participants on the phone prior to the interviews, I was aware that some of them had negative experiences with social workers in the past. Therefore, it was important that I took care to build trust with each participant as much as possible in a short time and attempt to develop rapport at the outset. One participant was celebrating her birthday on the day of her interview. She had brought a cake and candles and asked me to share it with her and to take a photo of her blowing out the candles. She explained that she would not be seeing anyone else on that day. It was a touching request and I felt privileged to be a part of her special day. Many others offered me a hot drink or other refreshment. As well as appreciating the offers, the time it took to prepare the drinks allowed time to connect with the person in an informal way.

I discussed the Information Sheet and Consent Form with clients, clarifying any concerns they had. I ensured that clients understood that even though I am a social worker, I understood that not all interactions with social workers were positive and I was keen to hear the 'good, the bad and the ugly'. I explained that I highly valued their views as a client of social workers. I assured them that I perceived them to be the experts of their experience and that this research provided them with an



opportunity to voice their ‘truth’ about their experiences of care or lack thereof, with the hope that their views and experiences could provide the social work profession with ‘food for thought’, and improve future practice.

## **Data analysis**

I used the steps outlined by Charmaz’s (2006) constructivist grounded theory approach to guide my data analysis. The analysis of the data began during the course of transcribing interviews. In this section of the chapter I describe the transcription process and then explain how I employed coding techniques to analyse the data, which consisted of open, focused, in-vivo and axial coding. Coding refers to the way that data is made sense of by labelling, categorising and summarising, each piece of data being considered (Charmaz 2006, p. 43). I then explain how memo writing and the constant comparison method assisted the data analysis phase of this research and led to my understanding of the data as a whole.

### ***Transcribing***

Bailey (2008, p. 130) explains that:

Transcribing is an interpretive act rather than simply a technical procedure, and the close observation that transcribing entails can lead to noticing unanticipated phenomena. It is impossible to represent the full complexity of human interaction on a transcript and so listening to ... the ‘original’ recorded data brings data alive through appreciating the way that things have been said as well as what has been said.

While colleagues had suggested that employing someone else to transcribe the data would be a valuable time saving measure, I chose to undertake this task myself. The transcription process prompted me to remember emotional responses and body language that were displayed by the participants, but not necessarily conveyed in the recording. If a third party had undertaken the transcription process, they would not have had this knowledge to draw on. Listening to the interviews enabled me to begin immersing myself in the data and to consider factors that I may have missed from simply reading the transcripts.

I used the Express Scribe software program to assist with the transcription process. I typed the transcriptions into a ‘Word’ document and as a proficient touch typist I

was able to do this quite quickly. The automatic 'pause' function on this program also helped me to transcribe the interviews in an efficient and timely manner. I was able to transcribe thirty minutes of interview recording in approximately one hour. I transcribed each interview verbatim and I included my own questions, comments and responses as well as the participants. I included all words such as 'um' and 'ah' and words and phrases that were repeated. This helped capture all the nuances of the conversation, indicating times when participants were struggling to articulate their ideas, or conversely punctuating particular views. I noted emotions that were expressed by participants in brackets within the transcript. These included crying, laughter, angry tone, significant variation in the volume of the participant's voice and expressions of joy. This added context and meaning to the data and helped me determine how segments of the data fitted particular codes and categories. I typed an 'I' in the left hand margin of the document to indicate the parts of the interview where I spoke and a 'P' to indicate the parts of the interview where the participant spoke. I used the participant number and pseudonym as the title for each transcript so that I could easily identify the participant while at the same time ensuring that they remained anonymous in the event that another person ever gained access to the transcript.

Each interview was transcribed within a week of the interview being conducted. This helped ensure that the conversation remained fresh in my mind. I made notes of my memories of non-verbal responses along the way. The transcription process enabled me to become familiar with the data as a whole. I began to document recurrent ideas and interesting insights that were evident in the data. Therefore, the initial data analysis began with the transcribing of the interviews.

Each interview transcription was mailed to participants on its completion, accompanied by the Letter to Participants Accompanying Interview Transcript (see Appendix 11). The letter reiterated that participants were free to change or delete any portion of the transcript without question. Two social workers and one client returned the transcripts, marking segments of the interview to be changed or deleted. I made the alterations to my copies and reposted the corrected editions for approval and removed any deleted segments and quotes that I had already lifted from the transcripts for use in my data analysis.

There was one exception to this process. As one client did not want the interview recorded, I could not produce a formal, verbatim transcription of the interview. Instead, as soon as I arrived home from the interview, I expanded on the brief notes that I had taken throughout the interview. I had managed to write down a couple of short direct quotes during the interview so that these could be used accurately. I mailed a copy of the completed notes to the participant and made a follow up phone call to check whether I had represented the participants' views correctly and if she/he wanted to add anything. The participant was satisfied with what I had written and happy for me to use the notes for the purpose of analysing the data and reporting the findings.

### *Initial coding*

The initial open coding involved a close analysis of each transcript and labelling each segment of the data by hand, by writing these initial codes in the left hand margins of the transcripts. While traditional grounded theorists (Glaser 1978; Glaser & Strauss 1967) promote line-by-line coding, Charmaz (2006, p. 83) suggests incident by incident coding as an alternative method, particularly when working with data that largely involves behaviourist descriptions of people's actions. I created codes for each section of the data that conveyed perceptions, beliefs, actions and reactions. On average a code was used for every two to three lines of data. In-vivo coding was also employed in this initial phase of analysis. In-vivo coding involves paying attention to specific terms and phrases used by participants, and in turn aids in making comparisons and identifying themes (Charmaz 2006, p. 55). In-vivo coding was particularly useful when considering the meaning participants gave to concepts and experiences. For example, the phrase 'just being there' was not one that I would have used, however it was frequently coined by the social workers who participated in this study. It became clear that participants were using this term to describe the value of a form of care that involved a compassionate presence. This term became one of the key themes presented in Chapter 6 of this thesis, which is the second findings chapter.

### *Focused coding*

I proceeded to develop focused codes from the data by beginning to categorise the data. Hence I started a more conceptual analysis of the data. This form of coding involves using the most significant and/or commonly used earlier codes and is developed by comparing data (Charmaz 2006, p. 60). Foss and Waters (2007) provide a hands-on, practical approach to conducting this form of data analysis. I began by using scissors to manually cut up each printed segment of coded data for every transcript from interviews with social workers. This ensured that all data was accounted for as I began to make sense of the codes. I then laid out the segments, creating categories from codes that seemed to relate to one another. For example, the codes 'warmth', 'non-judgment' and 'empathy' all fitted the category of 'caring qualities'. Cuttings from each category were placed in labelled envelopes for future use when reporting findings. I then repeated this process with the data from client interviews. Forty four categories were deduced from the social worker data and 32 categories from the client data. This process enabled me to identify both commonalities and differences in the data. A coded hard-copy of the complete data set was kept to refer to as needed. Table 2 illustrates examples of focused codes that were derived from initial codes applied to the data.

**Table 2: A sample of Codes Applied to Social Worker Participant Data**

<b>Focused codes</b>	<b>Initial codes</b>
Just being there	Helping client feel less alone
	The power of sitting with someone in the moment
	Just being with someone is sometimes the most appropriate intervention
Recognition of common humanity	Always possible that we could be in the clients' position some day
	Everyone needs care to some degree
	As human beings we are all interconnected and interdependent
Valuing the client	Putting the client first
	Recognising the clients' truth as valid
	Honouring the client

Table 3 illustrates examples of focused codes derived from initial codes applied to the data from client participants.

**Table 3: A sample of codes applied to client participant data**

<b>Focused codes</b>	<b>Initial codes</b>
Importance of care in social work practice	Care can make the difference between a life or death outcome
	Care is the most important thing of all
	Lack of care is isolating
Care as non-judgment	Feeling judged about one's choices is uncaring
	Appreciates feeling accepted no matter what
	Feel looked down on
Genuineness and honesty	Being real is important
	Social workers should do what they say they will do
	Pretending to care is worse than not caring at all

### *Axial coding*

Axial coding was employed as a way of identifying relationships between categories and moving from a descriptive to a more conceptual understanding of the data (Charmaz, 2006, p. 63). To support this process I typed up and cut out the codes deduced from the focused coding. I then laid out the labels that related to one another while looking for possible major themes. I repeated this process several times, moving the labels around. Each time I aimed to create a deeper understanding of the data as a whole and the story that social workers and social work clients were telling about care in social work practice. For instance, the focused codes 'picking battles', 'taking a stand' and 'considering risk' all related to ideas around resisting barriers to care which became a theme of the data. Others, such as 'just being there', 'listening' and 'non-judgment' related to clients' views of how social workers created a connection with clients. These focused codes led to the key theme of 'experiencing care through connection with social workers' being identified.

### *Memo writing*

Throughout both the interview and coding stages I continually employed memo writing. I used a journal to write anything and everything that seemed relevant to answering the research question when analysing the data. This step helped make sense of codes and to conceptualise the data (Charmaz 2006, p. 72). It was useful

when I began to write up the findings of the research. I included my own thoughts, judgments and the difficulties I encountered throughout the interview process. Memo writing enabled me to understand and minimise the way in which my own interpretations impacted the construction of the data analysis and my recommendations for social work practice. When I initially heard depictions of social workers' practice that emphasised the importance of attending to professional boundaries and speaking firmly with clients about the reality of certain situations, I did not think that these narratives aligned with a caring approach. It was not until I began to reflect more through journaling that I realised that the intent of the participants who spoke in these ways came from a place of deep care. It became evident from some social workers' stories that strong, respectful relationships were formed with clients as a result of being honest and open about limits to confidentiality, and highlighting likely negative consequences of clients' actions that may lead to further suffering. I then noticed that this realisation was supported by several of the client participants, who appreciated it when a social worker who they trusted and felt valued by was completely honest, even when it was not always pleasant for the client in the moment. I began to recognise that sometimes care was enacted and experienced from a stance of 'tough love'. It was often the social worker's attitude that indicated care more than the approach that followed. Initially I could easily have perceived the stories of 'tough love' as antithetical to care and as exceptions to caring practice in this study. It was through the reflective space of journaling that I identified that these participants' versions of caring practice were as valid as others who took a more outwardly empathic and compassionate approach, an approach that was more easily recognised as care.

### *Constant comparison*

Throughout the process of coding and memo-writing I continually compared the incidents described by participants and the codes I had identified. I considered how and if they related to one another. For example, after I had developed the focus codes, and written the codes on envelopes that contained the segments of data relating to those codes, I began to arrange the envelopes in different ways. Thus, I began to explore how the codes related to one another and I continued to move them around, making new connections between the codes which helped me to see the data in different ways. After separately establishing relationships between categories

from interviews with clients and social workers I then began to draw links between the two sets of data, exploring any themes that were evident across both data sets, as well as differences between them. This final step enabled me to see the overall story evident within the data, which I present in the following three chapters.

## **Concluding Comments to the Chapter**

This chapter has discussed the theoretical and ethical framework that was used to support this study. The use of a qualitative approach, guided by constructivist grounded theory was chosen as the most appropriate framework for meeting the aims and purposes of this research. Sampling and recruitment methods have been discussed, along with interviewing methods that were used to collect rich, meaningful data about participants' subjective experiences. An in-depth discussion of the way that ethical considerations and concerns were addressed, including principles of informed consent, confidentiality, anonymity and protection from harm has been provided. A rationale for ensuring that an ethic of care informed the research process has been included. Finally, the constructivist grounded theory approach to data analysis has been described in detail. Throughout the data analysis process I remained committed to interpreting the data in a way that did not misrepresent or question the participants' conveyed thoughts, actions and overall messages. This helped ensure that the practice theory I developed from my analysis was grounded in the data. All of these aspects of the research design worked in synergy with one another, and created a strong framework for answering the research question. The following three chapters present the key findings that have resulted from the methods used in data collection and analysis. Chapters 5 and 6 report the key findings from the interviews with the social workers who participated in this study. Chapter 7 presents results from interviews with social work clients.

# Chapter 5: Meaning and Features – The Social Worker Perspective

## Introduction to the Chapter

In the previous chapter I explained the methodology that I used to undertake this research. This chapter is the first of three results chapters, each of which provides findings that answer the research question: *‘How does thinking about, doing and experiencing care in direct social work inform an ethic of care for the profession?’*. The number of participants represented in each of the themes presented in these chapters is reported. The value of providing numbers lies in the way it assists in making the selection of themes transparent, offering a supplementary support for the chosen themes, and highlights to the reader what the most common ideas, practices and experiences were (Maxwell 2010; Sandelowski 2001). I acknowledge that reporting of frequencies does not always reflect the significance of the themes. Several of the sub-themes mentioned in the following chapters report numbers of only two or three participants. This data was considered important enough to be included because it was related to major themes, while presenting a different perspective. For example, all social workers spoke about how empathy and compassion are important features of care, with two participants discussing the idea of ‘compassion with boundaries’.

I begin this chapter by presenting a profile summary of social workers who participated in this study, followed by an outline of the main conceptual themes and sub-themes. As the title of the chapter indicates, I show how social workers understood care in direct social work practice in terms of its meaning and features. Making sense of the concept of care in social work was a necessary pre-requisite to describing how care was enacted in practice in the research interviews. I present the findings that relate to the first main theme, namely, the meaning that participants attributed to care in direct practice. While some social workers viewed care as a personal orientation, others saw it as being more practical, and many social workers



described care as both an attitude and an action. Several practitioners made a distinction between the care that is enacted and experienced in their personal lives and care in the professional context. There was a general reticence towards associating care in social work practice with maternalistic/paternalistic notions of care.

The second major theme identifies the features participants believed constituted caring social work practice. Valuing the other, empathy and compassion, listening, non-judgement, genuineness and honesty, respect and understanding were considered the key indicators of a caring social worker. The chapter concludes with participants' reflections on the relevance of care in social work practice, where presenting their views on the visibility and the importance of care in direct practice is presented. Social workers who participated in this study perceived care to be a key element of their practice and with the exception of one participant, they saw the need for it to be made more prominent in codes of ethics and social work education and training forums.

## **Participant Profile Summary**

Table 4 presents a summary of the key characteristics of all social workers who participated in this study, including their chosen pseudonyms, and their gender, type of organisation they worked in (government or non-government) and their years of practice experience.

**Table 4: Participant profile summary of social workers**

<b>Pseudonym</b>	<b>Gender</b>	<b>Organisation type</b>	<b>Years of practice</b>
Amber	Female	Non-government	13 years
Ashley	Male	Government	4 years
Billy	Male	Non-government	1.5 years
Cloudy Bay	Male	Government	30 years
Jade	Female	Government	4 years
Kate	Female	Government	4 years
Kellie	Female	Government	10 years
Lesley	Female	Government	12 years
Lou	Female	Non-government	6 years
Mary	Female	Non-government	4 years
RM	Male	Government	25 years
Sally	Female	Government	21 years
Shirley	Female	Non-government	18 years
Susie	Female	Government	6 years
Yasmine	Female	Non-government	20 years

## **Conceptual Themes – Meaning and Features of Care in Social Workers’ Practice**

Table 5 provides a representation of the first three main themes that emerged from the analysis of the data from the social workers who participated in this study. This table acts as a map to guide the reader through the chapter.

Even though ‘features of caring social work practice’ was the main theme, and this is what would normally order the presentation of findings, it conceptually makes sense to begin with the ‘meaning of care in social work practice’.

**Table 5: Conceptual themes: Meaning of care in practice and features of caring social work**

<b>Meaning of care in social work practice (n=32)</b>	Care as a personal orientation in social work practice		n = 12
	Care as action		n = 10
	Care as avoidance of maternalism/paternalism		n = 10
<b>Features of caring social work (n=70)</b>	Valuing/honouring the other		n = 15
	Empathy and compassion	Demonstration of empathy and compassion	n = 13
		Compassion with boundaries	n = 2
	Listening		n = 13
	Non-judgment		n = 8
	Genuineness and honesty		n = 7
	Respect		n = 7
	Understanding		n = 5
<b>Reflecting on care in social work practice (n=23)</b>	Relevance of care to social work practice		n = 15
	Thinking about the visibility and credibility of care in social work		n = 8

## Meaning of Care in Social Work Practice

Social workers described care in three main ways. In the first instance, most social workers viewed care as a personal orientation (n=12) informed by personal values, attitudes, knowledge and/or spiritual beliefs. Second, many participants argued that care necessarily required taking action of some kind (n=10). Third, social workers described how maternalistic/paternalistic notions of care (n=10) were inappropriate in social work practice. I will now elaborate on these themes.

### Care as personal orientation in social work practice

Two thirds of the participants in this study described care in ways that reflected care as something personal, inspired by feelings, orientations towards others and/or world views. Three participants argued that care comes from the heart rather than the mind. Cloudy Bay captured this view when he said:

For me I think it's a kind of a felt thing. I think you can communicate it in the way that you behave with somebody. You know, I can't switch on the care thing.

Amber echoed similar thoughts when she explained 'It's probably not rational. It's outside of thought'.

Three practitioners equated care with love and compassion with one saying, 'Care is just a feeling of love; it's something you do because it's inspired by love', and another, 'Love is the thing that pops into my mind when I think of care'. For three participants this idea was inspired by the work of Jim Ife. Cloudy Bay spoke about the influence of Ife, stating:

I remember reading something by Jim Ife on the love of humanity and I guess for me that's the cornerstone of social work. I was so pleased when Jim started talking about it... It seemed that we could talk about anything but the 'L' word and I thought, 'Well thank God someone has got the courage to put it where it belongs'.

Ashley drew attention to the idea that care is not only something that is felt by the person doing the caring but it is also something that is sensed by the person experiencing care. He commented:

I don't think you can put your finger on what it is that makes a caring interaction. Two people could say and do exactly the same thing, but one may be considered caring and the other not particularly so. Things like tone of voice and facial expression can make a difference I guess, and just really being present.

Some social workers talked about care as a natural response to suffering and injustice. Witnessing the suffering of others due to discrimination, stigma, marginalisation and structural inequalities evoked feelings of care. One participant spoke about how she could tell that she really cared about an issue of justice when she experienced a 'fire in the belly'. Jade shared a similar passion for caring about inequality and indicated that care extended beyond the individual, even when working in direct-practice roles. She said:

It is deep in my blood that people deserve to be treated fairly and equally and they should get what they need. I care deeply about these things.

## Care as action in social work practice

While a caring attitude was important to most social workers, many of them also talked about the importance of ‘doing’ as a way of demonstrating care. Many expressed a sense of responsibility to assist clients to make positive change in their lives, which often requires practical action. Responses conveyed the view that a caring nature is often not sufficient without action. One participant said, ‘It’s not enough for me to think something is terrible and then do nothing’ and another commented, ‘It’s about taking action to make things better’.

While most participants viewed action as an expression of felt care, Lesley took a somewhat different stance arguing that pragmatism often trumps displays of empathy and compassion when demonstrating care. Lesley said that:

It is never to me just about whether I’ve got the warm fuzzies...I know lots of clients who don’t even see being comforted as useful. They might want direction. They might want someone saying, ‘I know you can do it, come on, up you get’, that sort of thing ... that’s what they come to the social worker for.

Sally strongly believed that genuine care requires action, however she thought that action could be applied in many different ways. She stated:

You can’t always take action by assisting with some big change, like finding them a house to live in or sorting out their emotional problems. Sometimes it is about just sitting with them, but in doing that you can ‘walk with them’ so to speak. That is still doing something.

## Care as avoidance of maternalism/paternalism

Many (n=10) of the social workers who participated in this study rejected maternalistic and paternalistic notions of care, believing them to be antithetical to caring practice. Shirley explained that paternalistic ways of working are often detrimental to clients. She said:

That paternalistic notion of ‘I know best’, ‘I know what’s good for you’ ends up squashing that person’s capacities to make their own decisions and go the direction they need to go.

Cloudy Bay shared a similar view. In his words:

You have to be careful not to take over – you can disempower them. You know it’s well intentioned, but it can be harmful and disrespects the person’s capacity for their own authorship. I think that’s a really bad thing to do and counter to everything we are trying to achieve. You know, people would see that as

caring; they care so much they want to do everything for them... We have to be careful not to dishonour their capacity.

Kellie echoed the thoughts of Shirley and Cloudy Bay. She said, 'It is not caring to take over, you know, just organising everything for the person and not listening and not being respectful, and not really getting consent'. Susie explained her view that paternalistic care could interfere with self-determination. She commented:

Some might say, 'Oh I'm caring for them by helping them out'. But are they? They are well intentioned and want to help and be caring, but in doing so they are actually creating a dependency on themselves, or not really helping the client achieve the things that they want to achieve. It's controlling and even though you are working with them you have to keep in mind it's the other person's life – it's not your life.

Kellie and Lesley both equated maternalistic/paternalistic care with 'rescuing'. They considered this to be counterproductive to supporting clients to develop confidence in their own abilities and strengths. Lesley explained:

It [care] can reinforce the idea that the other person can't cope, that they need propping up, that they need rescuing, that they need care and it's very warm and comforting and it basically trains people in learned helplessness... That can happen. Care is not just mothering people flat out – that's diminishing.

In Kellie's words, 'I guess the wrong way to care is trying to rescue the person without considering what they might really want'.

Yasmine also separated paternalistic care from care in social work practice. She explained:

Care is a loaded word and can be seen as paternal. I think if we're talking about care in this research it's about that sense of empathy, a sense of concern, a sense of compassion and a sense of respect for that person and that it matters to you what happens to that person without you becoming invested to the outcome to the point where you're disempowering that person, taking over from them, pushing them in a certain direction because it's in their own, quote, best interest.

Sally explained that when she first heard about my research she automatically thought about care as a maternalistic response, something that she wasn't comfortable with. She said:

When I think about care the immediate response that comes to mind is really looking after somebody, that mothering sort of care, and that kind of doesn't sit very well with me. Now I have thought about it I realise that of course I do care, but I try not to do it in that way.

Mary had some reluctance in using the term ‘care’ in her practice, due to her view that it holds maternalistic connotations. She explained:

I don’t know if the word, like in my work, I don’t know if I’d use the word ‘care’ because it does have that notion of mothering and I like to separate that idea from my work.

The views expressed by the social workers in this research did not lead to a single definition or idea of caring practice, however, a common view was that care required more than just feeling compassion or concern for a client. Even those participants who did not specifically mention care as ‘doing’ or ‘action’ reflected this principle in the practice examples they used throughout their interviews, as will become evident in Chapter 6.

## **Features of Caring Social Work**

This section of the findings presents the social work participants’ views on the features that constitute care in direct social work practice. These included valuing/honouring the other (n=15), empathy and compassion (n=13), listening (n=13), non-judgment (n=8), genuineness and honesty (n=7), respect (n=7), and understanding (n=5).

### **Valuing/honouring the other**

The concept of ‘valuing and honouring the other’ was implicit in and underpinned all of the features of care that social workers who participated spoke about. Six social workers spoke explicitly about valuing and honouring the other. For example, Susie said, ‘Valuing the client for who they are, but also not just where they are now but recognising the potential and possibilities for where they can head as well’.

Cloudy Bay reflected these words when he said, ‘Care is about valuing the other as a fellow human being’. Sally spoke about care as honouring clients. She explained:

I really think a big part of care is honouring where people are at and honouring that people are experts in their lives and that they can be telling us what they need. I think we really need to honour people and not in a flaky sort of way, but just honour their journeys and what’s got them to here. We don’t even need to know their journey, the fact they are sitting here today and I honour that as a process.

Yasmine spoke about clients she had worked with who had experienced domestic violence, arguing for the importance of care in assisting these people to feel valued and worthy.

There was often that moment that challenged their whole notions of themselves as worthless, of not mattering...I am not saying if the intervention was more practical and less caring, maybe, that they wouldn't be pleased with the outcome, but when those things did happen they talked about them as being significant.

## **Empathy and compassion**

Empathy and compassion were often paired together as features of care in direct social work practice. I identified two sub-themes from the data: 'demonstrating empathy' and 'compassion with boundaries'. I now elaborate on these themes.

### ***Demonstrating empathy and compassion***

Empathy was described as feeling for and with the other, motivating a desire to alleviate suffering. Lesley spoke about empathy as a motivating factor that led to care when she said:

There has to be a higher reason for caring and I think more often than not that is about empathy. There is that feeling that if I were that person I would not want to be in that situation and that distress and I would want someone to help me.

Kate shared a similar sentiment, saying, 'Care means being empathic and compassionate, having sensitivity towards the person and what they are going through'.

Billy explained how he believed empathy often demonstrated care in the following way:

Well, I think it's very much about matching. Care for me is matching where the client is at straight away. I mean for me, the body language is huge in care. So, if I walk into a room and sit down, even by the time I sit down and haven't said a word, I hope to relay some sense that I understand something that is going on... and there is some ability for me to be able to listen to that. It is completely non-verbal. It is often completely unintentional. When you feel genuine empathy it is natural to match the client's language and body language because to some extent you begin to feel what they feel.



Yasmine linked empathy to the notion that all human beings are interconnected, arguing that empathy demonstrates a recognition of that connection to others. She spoke about empathy in relation to care as:

You cannot really care if you are cold and removed...care requires coming from a place of compassion and empathy.

All social workers believed compassion to be a key feature of a caring practitioner. Compassion was spoken about in very similar ways to empathy. Compassion was seen to be aligned with a feeling that arises when recognising the suffering of another, provoking a sense of wanting to alleviate that suffering. Sally stated:

I really love the Dalai Lama's definition of compassion. He says, 'compassion is observing suffering in the world; there is suffering; people do suffer', and so you do observe that. You see the suffering that happens for people but then you also have the responsibility to take action to stop the suffering. That's compassion, it is not just observing; it is not just seeing; it's doing something and that doing something could be out there trying to fight to change structures, service delivery, policies or it could just be sitting with that person and their suffering and not shying away from that. You can't demonstrate care if you shy away from that feeling of compassion. It is important to be able to sit with the discomfort it can bring and put the client first.

Ashley simply stated the relationship he saw between care and compassion. He said, 'Care and compassion – they are inseparable really'.

RM, Kellie and Shirley all said the true test of compassion is when it is felt towards a person who has inflicted harm on others. RM reflected on a training workshop he attended:

It's about finding that compassion. I went to see John Briere (a professor of psychology and psychiatry) last year and it was just fabulous. One of the big things in his talk last year was, 'We are all bozos on the same bus', and given the right circumstances and situation any of us could be in a certain situation. So, it's about not getting too ahead of yourself and not propping yourself up as this self-righteous person... you never know what circumstance you might be in that would lead you to do something. You know, would you kill someone? Would you beat someone up, would you steal from someone? And under what circumstances would you do that? You just don't know. So, to find compassion, it is important to remind yourself that you could be in that situation too.

### *Compassion with boundaries*

Both Lesley and RM rejected notions of care as always being about giving 'warm fuzzies', recognising the need for compassion while at the same time applying limits and boundaries. In RM's words:

I don't think care is just being nice to people. I think social work has a bad name because people sometimes think you sit around and hold hands and drink cups of tea. There's still some of that and there's a bit of a joke to it. I just don't think it's being everything to everyone. Um, yeah, and it's, you know, there are all the usual boundaries around lawfulness and legalities and obviously we would work within a legal framework, whether it be the law the public adheres to or agency law or privacy law or, um, there's always frameworks we have to work in as practitioners, be it in government or non-government agencies... there are some real limits to this. And I think having practiced for a long time – I think we all start out enthusiastic about all sorts of things, but there are some realities.

You know, you have to respect some things and handle them in a caring way, while also doing what we have to do.

I see care (in social work practice) as compassion with boundaries. I really believe in that word 'boundary'. We need to think about boundaries and think about what's possible and what's not possible.

RM believed that clients also viewed care in social work practice as necessarily containing boundaries. He explained:

When you set some limits they do appreciate that and you get that feedback. Often people are traumatised and when they tell their story, often people can go on and on and on and you don't know how to stop the person without saying, 'Look we need to keep the sessions to this amount of time because I don't think it's healthy for you to unload all at once', and often they will come back and say I'm really glad you've set some limits as it has helped me to feel safe.

Lesley expressed similar views to RM. She stated:

I don't believe in running around making sure everyone is happy and full of joy at every moment. Of course you work from a place of compassion but you don't have to layer on false things. Do your job well and you have it pretty much covered.

You can get lots of extrinsic reward that's fairly fluffy for being a high profile 'lovey-dovey' versus someone who has to do some pretty thankless, hard stuff for the greater good. To me that hard stuff is often more important and more caring in the long run.

Mary also believed that compassion in social work necessarily included boundaries. She differentiated care in the professional world of social work practice from care in the private realm, as summed up in the following statement:

I don't think there is anything wrong with talking about 'care' in practice but I would be more comfortable with such a term as 'professional care' or 'professional caring', just because I think it gives it a boundary. Otherwise if you don't have any boundaries you are going to try to do it all I think.

In a similar vein Shirley commented:

There's also, very importantly, the idea of professionalism within that you can care and be compassionate but not be personally involved with that person. I can care about what they've experienced as a human being but I'm not attached to that feeling from my own perspective. So, I think that's probably the key difference between care in your personal life and care in your professional life.

## **Listening**

One of the features most frequently raised by social workers as being indicative of care was 'listening'. Giving clients the space to be heard and share their story was considered to be paramount to creating a caring environment. Cloudy Bay explained:

I think people typically don't get heard. I think sometimes when you have a conversation with somebody they go, 'God, this is the first time someone has listened to what I have to say'. That makes them feel cared for and is crucial to a meaningful experience.

Sally expressed a similar view, arguing that:

Sometimes it seems what the person needs more than anything is to be heard. I think we so often underestimate the core of really being with somebody, which is listening...really hearing what they have to say and that is such a powerful intervention in itself.

Lou equated listening with believing the client when she said:

It's not about just listening but if they tell you that you know, the two year old kid that is sitting there like a little angel, that at home is a little devil, then be curious about that and believe them rather than say, 'Oh no, this little child could never be horrible'.

Jade explained that listening is the basis for building trust in a worker/client relationship. She claimed, 'Listening is very important and respect because that is the only way to bring that trust in the relationship and to show care'.

## **Non-judgment**

Non-judgment was another feature that was frequently mentioned in the interviews in explaining care (n=8). Social workers acknowledged that judgment is inevitable to some extent and necessary when conducting assessments with clients. At the same time, however, it was believed to be important for social workers to try not to

make assumptions when listening to the story of a client and to remain open to values and perspectives that differed from their own. According to Jade:

Being non-judgmental and just avoiding the assumptions about their personality or their behaviour. Just get that new information because that can help us provide the right service and the right care and support.

Shirley referred to non-judgment as being an important principle to consider when following professional ethics in social work practice. She believed that judgment is something that all social workers bring with them into their practice simply by virtue of being human, believing nonetheless that genuine care assisted in reducing judgment. She said:

Care is something that we need to acquire to work with someone in a non-judgmental way and that's part of our ethics as a social worker, to work as best you can in a non-judgmental way. I mean, you are always going to have judgment, but, it's like when there is a perpetrator that wants help, it's about finding that care and compassion.

## **Genuineness and honesty**

Genuineness and honesty were spoken about in similar ways to one another and overlapped in relation to care. It was generally believed that genuineness was necessary in order for care to be experienced by clients and that this required social workers to be authentic, open and honest. Mary expressed this view eloquently in the following comments:

Genuineness, openness and transparency... because you have to be so honest with yourself, because if you are not who you are, as deep and philosophical that is how can you expect that to radiate, and I think you have to look inwards before you can look outwards.

I think for me it is important to be genuine. I don't think for a lot of people it is. I think there are a lot of people who fake their care framework, but then justify what they do by the code of ethics and organisational framework which for a lot of people would be their care framework. It's not mine. It has to be honest and genuine.

Lesley said that genuineness and honesty are important when faced with conflict with a client and she equated dealing with such conflict in a genuine way with caring practice. Lesley spoke about times when she had become frustrated with a client and how being honest helped her to repair the relationship:

I might say, 'I know I was shitty last time we spoke but it's great that you are still prepared to come back'. You know, you will have some pretty tense moments, particularly if you are doing child protection or even school social work. You have to say, 'You know, come on... well it was really crap last week, but let's see if it can be better this week'. They really value that.

A similar comment was made by Sally. She explained:

I have felt hurt at times...I feel that I have put in a lot of energy and a lot of care and commitment and then I get abused and I can feel a bit personally hurt. I am a human being. I think it's about being honest with ourselves and saying, 'Yeah, that actually does hurt'. I think you can be honest about that though, with the client. There is a mutuality to care and sometimes being honest about these things can help build a partnership.

RM believed honesty to be a demonstration of care and sometimes involved telling a client something they may not want to hear. He expressed this view when he said:

I think it's honest [care] and I think the honesty relates to the limits, like, if someone comes in and asks for something that's unrealistic I don't think I'd say that can happen. It's not caring to make out something can happen when you know it can't. I might say, 'I don't think this is possible but we can explore this, so at least you feel some closure', but I think it has to be realistic.

## Respect

According to participants, respect and care in social work practice are interlinked.

Respect was deemed to be important in the professional context of social work practice in that it was seen to assist in avoiding paternalistic/maternalistic notions of care. Yasmine explained:

Clients talk about being respected and a sense of someone caring about what happens, which comes out of respect I think. Because care is a loaded term and it can be seen as paternal.

According to Cloudy Bay, respect linked to the idea of valuing the other:

So, for me it's about that recognition of the other as equal and valuable as a being and I think that goes beyond the human species almost. I think it is about having respect for all life and ecology.

Kellie drew a distinction between care and respect arguing that:

I think there is a difference between care and respect. Like, it's hard to work with someone who's frustrating you. You can still be respectful and give them all the information in the same tone of voice and everything, like a nice caring tone of voice. But this care inside is gone, it's not there, you are not going out of your way. You respect them as a person, but there is something missing, something from the heart. There is a difference.

## Understanding

The social workers spoke about care as being about attempting to understand the situation, thoughts and experiences of another. According to Susie, understanding requires putting aside one's own version of the truth in order to have an idea of what the client's experience is like. She explained:

It's not about finding the truth per se; it's about understanding what the truth is for that person as I recognise that there can be multiple realities in any given situation and it is crucial to have an understanding of the client's version of what's happening to them.

Billy also described understanding as an important feature of care, saying:

So, I guess where care comes in that's about not doing for and doing with and understanding what they need.

Kate believed that social workers need to understand why clients may sometimes be resistant to intervention. She explained, 'It's back to that understanding and for some people there are just so many barriers to participation'.

Mary felt it necessary for social workers to reflect on their own position and experiences in order to attempt to understand and care for the client. She said:

I mean, some of us do have more privilege than others and simply because of the family we were born into or whatever can make the difference. And understanding and knowing that or having that in your mind is part of trying to understand where the person's at. If we can't understand them, at least to some extent, then we are unlikely to be very helpful.

Participants said that care required integrating several features and that these features often overlapped. For example, compassion and empathy were often spoken about together, along with respect, listening, non-judgment and understanding.

## Reflecting on Care in Social Work Practice

Participants reflected on care in social work in terms of its relevance (n=15), and visibility and credibility (n=8). Most referred to care as an integral part of social work practice, yet it was an aspect of practice that was not spoken about frequently in general settings. I present this data in the following section.

## Relevance of care to social work practice

All social work practitioners that were interviewed for this research believed that care holds an important place in social work practice, although the degree to which this was the case did vary. Half of the participants viewed care as the very essence and foundation of social work practice, with one participant stating, 'It's the foundation, literally the foundation for my work', and another commenting, 'I think care underpins everything'. Ashley believed care to be the most important aspect of his practice. He said, 'Yeah, yeah, of course I think it's important. Yeah, it's the most important thing there is, and it's outside and above everything'.

Participants believed that the inclusion of care in otherwise competent practice could make the difference between an unsatisfactory or adequate experience for clients and a memorable and outstanding experience. Care often proves the catalyst for change. In some cases, such as when working with grief and loss, care was all practitioners thought they could offer, and therefore it was crucial to assisting the client. Amber spoke about the importance of care when working with clients suffering from depression. She said, 'The notion of care can really be at the core of what makes a difference in treating depression or it can be the core of suicide prevention'.

Yasmine, in clearly summing up the view that care makes a difference stressed that it is important that social work educators highlight the value of care in social work training. She explained:

So, if I had a magic wand it would be that these kind of ideas are always on the table with new graduates and the students and in supervision, because I think it's, again without that element of respect, compassion and empathy and without the time to connect and make relationships we are delivering a poorer, it's not a poor service, but a poorer service. I have heard people tell me that the care or compassion is the thing they remember most. Out of all the things from my contact with them they talk about 'the way you treated me'.... There are situations when no matter what you do, the person feels an intense sense of hopelessness. So, I'm not Pollyanna around that but it's a good place to start.

Participants expressed concern that care was generally being lost in the Western world, and at risk of being lost in social work. Mary reflected this view, claiming:

Oh, I've been very disheartened by Western society...it's taken away all collective sense of self which is probably why there is more of a need for social work anyway. Everyone is losing sight of care I think. I've got real issues with where it's going. Care seems to be a dirty word which is why we have a lot of the issues that we have, like homelessness. I think it is the context that's dirty.

Taking slightly different viewpoints, RM and Lesley stated that while it is important to demonstrate care in social work practice, caution should be taken to ensure that it does not get in the way of 'good practice'. Lesley believed that the type of care that should be delivered is partly context dependent. She explained:

It does depend on the context too...If you are a bereavement counsellor I think you need to be a caring person to want to do that work but if you are sitting there being deeply emotional about what the person has to bring I don't know that you are terribly useful as a counsellor.

RM believed that practitioners needed to be realistic about the limits of care. He said:

I think care is there enough already in social work. I think it's more the boundaries and limits that could be talked about more. We might have different understandings of care, so there needs to be more a common theme of how we do it, common themes and limits and boundaries. I just don't think that boundary thing is done well in social work and I think that's the bit that needs to be focused on.

The majority of social workers who participated in this study believed that while care is highly relevant to contemporary social work practice, it is not given the credence it deserves. RM and Lesley diverge slightly from this view, delivering messages of caution that a focus on care does not override common-sense professional boundaries and a focus on safety of clients and other members of society.

## **Thinking about the visibility and credibility of care in social work**

Most social workers stated that prior to receiving the information sheets on this research, they had not really considered how they would define care in their practice. Care was not a concept that had been highlighted in their social work education, training or professional development. The three participants who already had a clear idea of how care related to their framework for practice had been exposed to curriculum content on care that had been included in the Social Work program at the University of Tasmania in recent years. Kate spoke about how this learning had helped her to think about care in her practice and proved to legitimise her own ideas that care was a valuable component of her practice.

After returning to study to do my masters in social work it was so refreshing to hear that stuff on care. It was really nice and we need that theory of care. I



knew there was something missing when I studied the first time around...This content really confirmed for me something that I knew was important in practice but was never really talked about before. It gave credibility to something that I was already doing but somehow felt was not always seen to matter that much.

While the other 12 participants had not had any formal learning specifically related to care in practice, they were able to articulate what it meant to them after reading the information sheet and considering the questions asked throughout the interview.

Lou explained this when she said:

No, I never really heard talk about care. At uni they would talk about being compassionate and all that sort of thing but that word care wasn't thrown around. I hadn't actually thought about it until I read your information, not in a formal way anyway.

Several participants commented on the value of participating in this research which provided them with a rare opportunity to think about care in their practice. While care was important to Shirley, she had never really articulated how or why this was so until she participated in this study. She said:

I just really like your research, your topic, yes... The idea of an ethic of care has made sense of things that I already think about and do but hadn't really formalised.  
You know, when I first decided to participate I didn't know what I would say, but it's all there, I just hadn't really thought about it in terms of an ethic of care before. In a way it's a no-brainer; you could say, 'Of course, of course it's important and part of what I do', but maybe this kind of research can put it at the forefront. So good on you!

Sally also found that the opportunity to participate in this research helped her reflect on care in her practice. She explained:

We could go on for hours here. I would just like to say that through the conversation it has been a great opportunity for me to reflect even more. There are so many elements to care that I hadn't really sort of clarified, or had the space or time to give thought to.

And Kate said:

This is a fabulous opportunity. It just gives me another forum to talk about what I do and why I do it and reflect on it and confirm what it means to care. It's really nice – it's awesome. People should jump at the chance to do this.

Several participants spoke about the visibility of care in the AASW Code of Ethics. Amber argued that care is already embedded in the Code of Ethics, although she believed that it could be made more explicit. She commented:

It's absolutely embedded in the principles such as self-determination and human worth. It's about helping people achieve their full potential or to live a quality life, so it's embedded in there, but I suppose it's not really spelt out as care.

Cloudy Bay also reflected on the presence of care in the Code of Ethics. He stated:

I see the Code of Ethics as being about respect and justice. I suppose it supports the notion of care but care is something more. Justice is about a whole lot of things – it's about systemic justice, it's about treating people with respect and decency, but that's a political stance. It's a human construction, whereas care is about acknowledging the other as a fellow traveller and somebody who should be afforded all the opportunities to satisfy their desires. So, it is different. Care is not articulated *per se* – well I don't think it is.

Kate did not believe that care is made explicit in the Code of Ethics. She argued:

It is sort of there, but it's just a shame the Code doesn't talk about it more clearly. Maybe it's a fear of that fluffiness – I don't know. I think we need to tell the AASW (Australian Association of Social Work) that they need to revise the Code of Ethics again.

Mary agreed that care is absent in the Code of Ethics, although she claimed to understand why this is so. She explained:

When you think about it, it can't cover everything and I don't think it aims to either. I think that there is that concept that it does cover it all, but I don't think that there's anywhere in it that it says it is the all-encompassing document for the dynamic world of practice. It's a guide and I think it's a good starting point if you are having ethical dilemmas or worries in your practice. You would probably go to it and have a browse but I also think you need to go much wider than the Code of Ethics when thinking about ethical practice.

Four participants mentioned that a commitment to care was the thing that brought them to social work in the first place. Susie talked about the influence care had on her decision to study social work, although she said that she soon noticed that talk of care did not seem to feature in the professional realm. She explained:

I guess right back from the start the reason why I did social work was because I care about people. We care about people and situations and enough to actually dedicate our careers to actually wanting things to be different for people. I don't understand why care is not talked about more though. It seems to just sit in the background.

Mary believed that a natural inclination towards care played a part in her decision to pursue a social work career, although she was concerned that the individualistic focus in social work today undermines care. She explained:

I remember a teacher from high school wrote on my report, 'Mary is the carer'. I suppose in my friendship groups I would be that person and she could see that. I think as a social worker I have learned to fine-tune that care stuff a bit. You don't hear much about it though in the social work profession, which has really surprised me. I think it has got a lot to do with the individualistic focus in today's society. It would be good to counteract some of that with a focus on the connectedness of humanity and a wider sense of the other.

## Concluding Comments to the Chapter

In this chapter I have presented how social workers articulated the meaning and features of caring social work practice in spite of the fact that most had not previously thought a great deal about what care meant in terms of their professional practice before viewing the Information Sheet for my study. All participants believed care to be an important part of social work practice, yet concerns were raised by some practitioners that it is not given a prominent place in the profession. Many participants considered that the mention of care appears to be hidden within codes of ethics and practice principles and models rather than being given emphasis as something important in its own right. Several participants argued that care is the very essence of social work, yet they felt that it was being lost in contemporary practice. In contrast one participant, RM, felt the emphasis on care was already present and sufficient, and caution should be taken to not allow care to overtake reason and professional boundaries. In spite of this, the stories he shared from his own practice reflect a commitment to demonstrating care (as becomes more evident in the next chapter).

This chapter has created a context for the next results chapter which focuses specifically on presenting themes in relation to the operation of care, explaining the way that the social workers who participated in this study 'do' care. The ideas expressed in this chapter will be further illuminated in Chapter 6 as the social workers speak of specific practice situations, along with the many challenges they face when attempting to implement care.



# **Chapter 6: The Operation of Care in Direct Social Work Practice**

## **Introduction to the Chapter**

In Chapter 5 I presented findings about the meaning and features social workers who participated in this study attributed to care. This chapter focuses on the ‘doing’ of care. Participants provided examples from their own practice to illustrate how the abstract notions of care discussed in chapter 5, operate in the real world of direct social work practice. I begin the chapter with a summary of the main conceptual themes presented throughout the chapter. The first theme is titled ‘Doing care in direct social work practice’. Findings in this section illustrate what enacting care looked like in practice. It involved meeting the client’s needs, doing the little things that demonstrate care, which sometimes meant just being there, building relationships, and being prepared to go the extra mile. The boundaries and limits that were considered to be a part of professional caring are discussed in reference to specific practice situations. Doing care in direct social work practice also involved doing self-care, in which taking care of the self was considered essential in order to have the capacity to care for others.

I progress the chapter with the second major theme, ‘Care and context in contemporary direct social work practice’. This section presents social workers’ accounts of the barriers to care that they face in their practice contexts. Economic and time constraints, risk assessments, focusing on individual responsibility, facing criticisms of care, and personal limitations were identified by participants as the main barriers to care. The chapter concludes with social workers practice examples of enacting resistance to these barriers, where social workers demonstrate through these actions a moral commitment to caring practice as they grappled with ethical dilemmas created by barriers to care. Taking a stand, bending the rules, picking battles, justifying care and taking risks constituted their practices of resistance and

these practitioners demonstrated how care operated as an ethical stance in their professional lives.

## Conceptual Themes of the Operations of Care in Social Workers' Practice

Table 6 provides a representation of the remaining themes that emerged from the analysis of the data from the social workers who participated in this study. This table also acts as a map to guide the reader through the chapter.

**Table 6 – Conceptual themes of the operations of care in social work practice**

<b>Doing care in direct social work practice (n=50)</b>	Meeting needs		n = 9
	Considering boundaries and limits		n = 9
	Self-care		n = 9
	Just being there		n = 8
	Building relationships		n = 7
	Going the extra mile		n = 5
	The little things that demonstrate care		n = 3
<b>Doing care within the organisational and political contexts (n=65)</b>	Barriers to caring social work practice	Economic constraints	n = 8
		Time constraints	n = 7
		Risk assessments	n = 7
		Focusing on individual responsibility	n = 5
		Facing criticisms of caring practice	n = 4
		Personal limitations	n = 4
	Resisting barriers to care by taking a moral stance	Taking a stand	n = 11
		Bending the rules	n = 5
		Picking battles	n = 5
		Justifying care	n = 5
		Taking risks	n = 4

Even though ‘doing care within the organisational and political contexts’ was the main theme, and this is what would normally order the presentation of findings, it conceptually makes sense to begin with the theme, ‘doing care in direct social work practice’.

## **Doing Care in Direct Social Work Direct Practice**

This section of the findings presents the social worker participants’ descriptions of ‘doing care’ in their direct practice. The sub-themes that I identified from participants stories were meeting needs (n=9), considering boundaries and limits (n=9), self-care (n=9), just being there (n=8), building relationships (n=7), going the extra mile (n=5), and the little things that demonstrate care (n=3). I begin by reporting how participants described doing care as being about meeting the needs of their clients.

### **Doing care means meeting needs**

Meeting the needs of clients involved paying attention to the client in order to understand and recognise their experienced needs as opposed to making assumptions about their needs. In Jade’s words, ‘I can’t act outside what people tell me. If I don’t know, and there is so much I don’t know, I ask, “Can you tell me? You let me know what you need”’.

This idea was reflected in Shirley’s view. She explained:

I always try to use a person-centred approach to find out what that person actually wants, what they are hoping to get out of coming here. That’s one of the first questions that I ask when I meet somebody, ‘What is it that you would like? What do you hope to get out of this and how can I help you achieve that?’. Otherwise you are just making it up, making assumptions and that isn’t caring about them.

Three participants emphasised the importance they placed on considering the uniqueness of each client in their practice as they attempted to meet their needs, highlighting the value of ‘considering each circumstance without making assumptions’, meeting each client with a ‘clean slate’, and ‘looking for the unique

factors that come into play'. Sally spoke about the importance of not making assumptions. She commented:

It is important to consider each circumstance. We can't make assumptions. You know, you could think, 'the last person was experiencing domestic violence and they had three kids as well, so this person must be experiencing something similar'. Hello! No! Not necessarily! We can't know that until they tell us, we can't know that.

Kellie provided an example of a lesson she learned about making assumptions about clients' needs. She explained:

I got a referral to meet with a woman whose husband just died and my initial assumption was, 'Oh she must be really upset'. I went up to her and said 'I'm really sorry about your husband' and she said, 'Oh, I'm really bloody happy, he was an absolute pig to me, bashed me up for years', and I quickly thought 'Ok, you never assume, you can never assume'. So, I always ask, 'How is this for you?'. I never just say, 'I'm sorry, you must be feeling sad'. I say, 'How's that for you?', because it can always be different to what you expect. It was a real shock... she was quite happy. Nothing surprises me anymore because you get so many different things and responses.

Several social workers explained that there were times when the needs of clients were guided by the intuition or practice wisdom of the social worker. According to Sally:

Sometimes I might want to ask a question, but it seems out of context. It keeps coming back to me, so I ask the question and do you know what? It is 99 per cent of the time that question that makes a difference even though it might not seem to make cognitive sense in my mind to ask that. So, I have learned to trust that. From a care perspective, we need to be careful what we say to people, but at the same time people tell you if you are on the wrong track. They will say, 'No, I don't feel like that, I feel like this'. Great! They have told you how they feel and so you've got it. You have a better idea of their needs. So, I don't know – is it intuition or is it practice wisdom?

Amber relayed a story of a woman she had been seeing who had committed a crime. She decided to go to the police station to check what was happening. She explained the situation and how her intuition guided her actions in this case:

She was crying and I went up to her and did something which other people might say was the wrong thing to do. I put my arm on her shoulder and she actually put her head on my shoulder. So, fortunately that was the right thing to do. I just held onto her, but I guess there is the question mark that maybe I just fluked it, because it could have been the wrong thing to do. It was a gut reaction. For me it was the only thing I could do and at that moment I felt it was what she needed. She seemed so frightened and exposed. It's a bit like if someone gets up to make a speech and they are terrified, you are not going to just leave them there alone.



The need for human touch was also something that Cloudy Bay talked about:

We had a poor chap whose son had been run over by a car and this chap was just beside himself with anguish, rolling on the floor, wailing. I just held him. It was the most natural thing to do and it was what he needed. I could have just sat there and tried talking to him, but that's not what he needed at the time. After a while he began to calm down and talk it through, but to begin with he was just beside himself with stress and I knew holding him was the appropriate thing to do.

## **Doing care means considering professional boundaries and limits**

The idea of 'compassion with boundaries' was mentioned as a feature of care by RM and Lesley. Seven other social workers in this study said that professional boundaries impacted on their practise of care. Participants acknowledged that there are limits to the care they can offer in their professional role. The degree to which this was the case varied depending on the situation, with most participants expressing a preparedness to negotiate or cross perceived boundaries such as those around self-disclosure, accepting gifts and offering a client a hug. Shirley explained that difficulties can arise when clients confuse care with romantic feelings:

What do you do when your client says they are in love with you? You know, most people go, 'Oh my God, that's the end of the therapeutic relationship'. Well actually it's not, but it's something you need to work with and have boundaries around. I mean it's an interesting thing to happen because they might not have had anyone care about them before and if you then abandon them then that's just perpetuating the problem they have had all their life. So, if you are nice to someone they can think, 'Wow, they must be in love with me'. So, that's why you also need to be careful with care as well.

Billy shared similar concerns when he stated:

I mean I am a young, essentially single male who is working with people roughly the same age, working with young women and young men and there are so many ethical boundary things that it is incredible. So, boundaries is something for me, that is so constantly on my radar it is not funny – how I walk down a hallway, how I stand in the room, how I sit, where I sit, what I wear, eye-contact, the whole lot. It is constant.

RM noted that addressing limits around confidentiality were sometimes perceived to be in conflict with care. He spoke about how he tried to manage necessary breaches of confidentiality while maintaining care:

Someone might be in a situation with a client and with an abusive partner and they will say, 'Look I don't want you to tell anyone'. I mean, we have to report, but I think it's important to keep them in the loop and say, 'Look I know you don't want this, but we have to and it's for your own safety', and explain all that. It goes with the territory and sometimes we have to do the hard stuff. I see it as ultimately the caring thing to do, but often the client won't see it that way.

According to Mary, boundaries around the degree of care, in terms of how involved she became in the lives of her clients, needs to be considered. She spoke about the conflicts she faced when working with children:

I often think, 'If only I could give them a bath and take them home because that would essentially solve their problems and give them love'. You can see all the things they need but I'm not the person who is going to take them home at the end of the day. But, in this particular role, knowing you can do what you can do to enact change but that there are boundaries is important. Otherwise if you don't have any boundaries you are going to try to do it all I think. I suppose it's that ethical side of it, just knowing that professional scope and what that can allow.

Other participants had 'loose' or more flexible boundaries in their practice. Sally spoke about the value of some self-disclosure in her practice, while retaining boundaries in other ways. She explained:

I will self-disclose. That's why I call my boundaries loose compared to many other social workers. I don't even like that word self-disclosure...I just want the other person to know a bit about me as a human being. There has to be levels of course and that's where boundaries come in. You know, you're not going to say 'Oh guess what happened to me?' and have the person end up working with you. At the same time I don't want to be the expert, you know where I am the one in the position of power where you are going to reveal all about your life and I am not going to reveal anything to you about me. I do, however, have very strong boundaries around power and the potential misuse or abuse of power.

Lou shared similar feelings about self-disclosure. She said:

I'm sitting talking to a woman whose husband left her two years ago and she has a couple of kids and it's really hard and I will sit and look at her and say 'It is hard isn't it, it's really hard to be a single parent, when I was and I still am this is what it was like'. It's about me letting them know I know exactly what they are saying. So, I don't have any boundaries about that sort of stuff. I guess my boundaries are less than some but of course I do have them. I'm not going to go and get drunk with a client.

Kate explained how she had come to realise that there is no 'hard and fast' way of attending to boundaries. She believes that the line between boundaries is blurry

rather than fixed, but that care needs to be taken at times to avoid crossing the professional line.

The idea of boundaries was one that was really interesting to me as an undergraduate because all I can remember about boundaries is you shouldn't accept any presents from clients, and hugs, and you shouldn't touch and all that. And it all sat really uncomfortably with me because I guess doing social work came from this place of love for me and care for people, and I guess over the past four years it's been about negotiating what are my boundaries, being comfortable with what I am doing. And it's really interesting. I don't know if caring too much is the right term but I think, yes we can sometimes go in there and provide something for someone and it could be seen as we are overstepping the mark. I have learned to work out what my boundaries are I guess, be flexible at times, while also being careful not to get into dangerous territory.

It is evident that participants viewed certain professional boundaries, including limits to confidentiality, limits to personal involvement with clients and limits to physical contact with clients as necessary even if they were perceived by clients as in conflict with caring practice.

### **Doing care means self-care**

Nine of the 15 social workers who participated in this research spoke about the importance of self-care. According to participants, self-care referred to 'taking time for themselves', maintaining some degree of emotional distance from the client, eating well and regularly exercising, gaining sufficient rest, and seeking regular professional supervision. While some believed self-care to be important for the worker's own well-being, others believed that without self-care, care towards the client could not be maintained. In Billy's words,

We talk about giving and giving and caring and caring, but I think we need to think about how we care for ourselves as well. It is incredibly important.

For Yasmine it was about balancing self-care with care for others. She explained:

We know that strong emotions can affect the way that we react and act towards others, so we need to take care of ourselves while at the same time be able to empathise with the person or the group or the community we are working with.

RM expressed a similar view when he said:

I think the self-care aspect is an important one as well, because if we don't do that we won't do the other stuff well either. I think I've always been mindful of that.

Lesley also believed that balance between care for self and others to be important.

She stated that it could be tricky getting the balance right however:

You would burn out really fast if you didn't keep some emotional distance, but then sometimes you see someone who is so switched off emotionally they have no insight into what the story might mean for a person and that isn't good either.

The risk of professional 'burn-out' was considered to be a significant concern to three participants. Kellie and Jade shared the following comments:

We need to take care of ourselves so that we don't burn out because then we can't really care (Kellie).

I find it really important to talk to someone senior to me when I am struggling because if I don't I could easily burn out (Jade).

Social worker participants had a diverse range of ways of caring for themselves, such as 'getting into nature', 'regular exercise', and 'eating good food'. Some needed to take small breaks through the day to 'clear their head'. Shirley had seen first-hand the effects on fellow social workers not employing self-care. She explained:

I know some people I trained with had had terrible experiences in their own lives and so there was a real emotional and personal attachment to their clients stuff. They were quite pained and it was a real struggle for them and I felt really, really sad for them. They had so much to give and offer, so much insight, but it was a difficult journey because they needed to learn when to pull back a bit and care for themselves in all of that.

Cloudy Bay was more reserved than other participants about the notion of self-care. He acknowledged that self-care is important, but expressed concern that arguments about self-care can become excuses for a lack of care towards the client. He argued:

I just wonder, you know, sometimes self-care can go too far, where it becomes 'all about me'. I try to help someone if I can and leave my own stuff at the door. I get a bit frustrated because sometimes I think social workers should be good at self-regulation, good at self-care, come into work and leave their baggage at the door and get on with their job. But, we are all imperfect and maybe that's unrealistic.

## **Doing care means just being there**

Over half of the social workers who participated in this research spoke about how they demonstrated care by 'being with', 'being there' and 'sitting with' their clients.

Kate talked about the way that she viewed just sitting with a client as a powerful intervention in itself:

When she was admitted [to hospital] she was very, very unwell and quite delusional. I knew her from previous admissions and I just sat with her at one stage and I didn't even really know if she knew that I was there. I just sat with her and I can't even remember really what we spoke about and then a couple of weeks later when she became well again, she said, 'I remember when I first came in and you just came and sat with me – thanks for that'. It really confirmed to me that this is an intervention; going to someone with just the idea of loving them and caring for them, that can be an intervention sometimes. There can be huge amounts of power in that.

A similar sentiment was expressed by Yasmine when she explained:

Many women who I spoke to who had experienced domestic violence had lost all sense of respect and self-esteem. Having me just sitting with them in the middle of the night – they remembered that. They talked about just having one person in that one moment. They looked back and it was the beginning of change for them.

Several social workers spoke about the value of just being there at times when they felt nothing else could be done. Ashley reflected this view when he said:

I don't think there is an action involved always and sometimes the best thing is to do nothing. You know, that is caring – doing nothing and just being. Especially in work like palliative care; just being and allowing the person to be, opening a space or presence for them.

Cloudy Bay spoke about the importance of 'just being there' when working with people around death and bereavement. He said:

When you are around death all you can do is bear witness. Just to have that human contact is really important. So, you know, I think once you realise the importance of that and have that awareness it's always with you and hopefully it continues to inform your practice.

Jade shared these views. She reflected: 'I have a lot of people who need help but there's nothing I can do nothing but be there with them and that is care'.

Sally explained that it is easy to feel helpless at times when no practical action seems available or relevant, however on reflection she could see the value of 'just being there'.

I think sometimes when somebody is in a very, very deep emotional state, in my experience anyway, there is a helplessness that I feel. It's like, 'What can I do?', but there is nothing, really there is nothing. But there is, I can be with

them, I can be with them in that. Caring at those times is not trying to do something about their distress. It is just sitting there with them.

Yasmine shared a powerful story about a young woman she came into contact with in her work as a new graduate. Yasmine worked in a context that was based more on providing practical assistance than counselling. It soon came to her attention that the woman was dealing with serious suicidal thoughts. The woman had a history of attempting to end her life and she was deeply depressed at the time she visited Yasmine. Yasmine made the time to connect with the woman. She saw her on several occasions and suggested options for further help. While this was outside of her usual role, she felt she could not simply refer the woman on to someone else and have no further contact with her. The woman was already under specialist mental health care; however nothing seemed to be helping. Yasmine described what happened a few weeks after her last contact with the young woman:

A couple of months later her father came in and told me she had killed herself. I was completely shocked. One of the things he came in to tell me, and thank me for, was the difference I made in his daughter's life. I was flabbergasted! I felt like I had been no use at all but he told me what it had meant to her to talk to me and feel well treated. I can't remember the exact words, so I will tell you the feeling. The feeling for me was that he was trying to let me know he felt that somebody cared about her and she talked about that and he said there wasn't anything anybody could have done; that they had tried a number of things and that eventually she was successful in taking her own life. I thought about that a long time afterwards in regards to what was good practice. Was good practice that I made sure she didn't kill herself? Was I a failure? If she had stayed alive would that have been a successful outcome as a social worker? I don't know but I have never forgotten what he told me. He came in to say she had talked about me and she had written about it. She had written in her diary that it meant something to her to have someone care, so I guess it did make a difference in that way even though the outcome might suggest otherwise. From that day I began to believe in myself more. The father gave me a real gift in telling me that. How often do you actually get to hear that sort of thing? You rarely hear things like that down the track. From that one of the things I have often said to other social workers is, 'For what it's worth, you never know what difference you have made'.

## **Doing care means building relationships**

Many participants mentioned the importance of building relationships with clients in order to show care as well as to affect change. Building relationships were central to Billy's caring social work practice. He stated that:

I wonder if you can build a relationship without care? I mean so much about clinical work, 90 per cent of it is relationship and I don't understand how to build a relationship without meeting the person where they are at. You know,

sometimes care might have to be reined in for all sorts of reasons, but when that happens it often means that the relationship has slipped and that's probably 90 per cent of the workers doing. So for me those things [care and relationship] are completely related.

Shirley explained that in her practice many clients arrived emotionally damaged and traumatised with little trust in people, especially professionals. She believed connecting with clients and building relationships needed to precede engagement with therapeutic intervention in her work. She commented:

Often when I go to case meetings someone will ask, 'What do you do with such and such, what models do you use?' I say, 'Well, we are just having a relationship'. What I mean by this is we are not necessarily doing anything therapeutic. I actually allow the client space to engage with me and give them a chance to feel safe and that can go on for many visits. It took me a long time to stop saying, 'Did you think about doing such and such?', because that's just so abrasive to some people.

Mary shared a similar comment:

I can see so much value in just building relationships. I haven't even started thinking about formal interventions because they haven't had that chance for someone to listen to them and have that basic relationship-building with someone...I started seeing really positive changes happening just from that. I have seen research since that says change can happen up to something like 30 per cent just on relationship and then the CBT or narrative or solutions focused work or whatever else comes so far down the line. It is that basic caring and relationship-building that sets up anything else you are going to do. Otherwise the client may just see an agenda that does not necessarily position them, as a person, as the focus.

Building relationships with colleagues and other professionals was also something that Kate, Kellie, Mary and Susie mentioned. They believed that care in practice extended beyond working with clients. Their comments included:

You have to have a good relationship with the other professionals you work with. If you are going to facilitate change and change the context you are working in. Showing that you understand and care about their position even if you don't always agree helps build trust. That stuff is as important as the work you do with clients you know (Susie).

Building relationships with the doctors and treating them with the same care and spending more time in the tea-room with them – that's important too, as our values shouldn't just stop with our clients (Kellie).

I remember I worked with this fabulous social worker in my first year out and I was sitting in her office and I was bitching about someone I was working with and she said to me, 'You know, we talk about how we are respectful and non-judgmental and caring with our clients, but we can't do that with our colleagues. What's that about?'. Gee, that challenged me, it really did, because

the clients are the easy bit, because that's where our hearts are; that's what we want to do (Kate).

Lou acknowledged that building relationships is not always easy. She commented:

Caring and building relationships is hard work. It's hard to build relationships because we've got people coming in who don't feel it's the best place in the world to be going to. Sometimes if I know someone is coming in, but not to see me that day, I will 'accidentally' bump into them just to say hi. Those sorts of things help.

## **Doing care means going the extra mile**

'Going the extra mile' relates to decisions and actions that move beyond what is often expected in the social work role. Jade summed up this idea stating that, 'A social worker who cares will go further and have the time.' RM provided an example of 'going the extra mile' as he spoke about an after-hours chance encounter with a client:

I was coming back from a trip at the other end of the state and I knew this client had been a bit of a risk and I saw this locked-up van by the river and I thought, 'Oh no!'. Like, I knew his vehicle and I thought, 'Do I or don't I?' and I thought 'Yeah, I will'. So, I pulled up and he wasn't around. It was sort of a bushy area and then he came out from the river and he said 'I've been fishing'. Anyway I said 'Are you ok?' and he said 'Yes and no' and we had a bit of a chat and it was through that that I was able to get him into a facility and that was a bit of a turning point for him...I think that was about caring, about doing that bit extra. I think he was able to see that as a bit of a turning point.

Lou shared a story that demonstrated 'going the extra mile'. She explained:

One of the mums who has a child with a disability starting school next year was really nervous. So, I asked 'Would you like me to go along to the school and meet the teacher with you?'. I could see that she was really scared and I wanted to be there to support her...I guess that comes from a place of care and that's my way – I'm a doer more than a talker.

On the morning of her interview with me, Kellie had another professional in her organisation ask if she could look after two young boys for a few hours as their mother had taken very ill and had been admitted to hospital. Alternative arrangements for the boys' care were being made but could take some time. Kellie said:

I was just naturally happy to do it and I knew we had a DVD player out the back, so I thought that would keep them entertained. However, another colleague here made a comment, 'Oh, we're not a baby-sitting service'. So, I checked with my manager and he said, 'Yes, that's fine, it doesn't happen often'. We're human beings you know. We've got to care! We can't just say,



‘Oh no, I’m better than a baby-sitter’. Yes, I did have other commitments that day, but I was prepared to work around them. I saw this as a part of my role, but apparently the other person didn’t.

Ashley believed that he was more likely to ‘go the extra mile’ when he related to and liked a client and he was less likely to do more when a client was rude and difficult to get along with. He spoke about working hard to advocate for a client he had recently worked with:

He had missed three appointments at Centrelink and his payment was going to be cut off for eight weeks. I felt for him as he did have some understandable reasons why he didn’t attend. So, I spent extra time writing reports and making phone calls. I advocated to have the two week payment penalty rejected, which is very difficult to do. I had to have this discussion with the customer service advisor for a very long time to convince him that the social work report was actually evidence and that the customer shouldn’t have to go out and get a heap of evidence when he was a complete wreck.

In contrast Ashley spoke about how his approach would have been different if the client did not engender the same level of compassion in him:

I definitely wouldn’t have argued with the customer service officer for so long and I wouldn’t have got so much information out of that person, because that person wouldn’t have trusted me to let me in on it all. Also I would have wanted to terminate the call with the client much quicker, so I wouldn’t have asked probing questions. I would have skipped over it all. I’m not saying that’s right. It’s definitely not. I am just being honest here.

## **Doing care means doing the little things that demonstrate care**

Several social workers spoke about care as sometimes being about showing consideration through small acts of kindness that extended beyond the normal call of duty. Lou talked about how she often showed care through ‘the little things’ arguing that some social workers appear to be too ‘precious’ about their professional role:

If you have to make someone’s bed, make their bed, or if someone needs a cup of tea, make them a cup of tea...Like, one poor mum had a baby and a toddler and it was raining and so I thought, ‘Mmm, she is struggling to get the kids in the car’. So I got an umbrella and took it out for them. That to me is caring. Plus those sorts of things can help create a connection and get you working with someone.

Cloudy Bay spoke in a similar way about lending a helping hand when needed, providing an example of a home visit to a client:

I asked how he was and he said that he had tried to drive his car but the battery went flat down the hill and he got stuck. So, I helped jump start the car and you

know that's something I would do for anyone. Some people might say, 'Oh that's not your job', but I could help so I did. It's as simple as that.

Care was described as sometimes being about trying to brighten someone's day by being prepared to engage with them in ways that did not fit with the norm, or slightly placed the social worker out of their comfort zone. Kate talked about an interaction she had with a mental health client:

The other day I walked into the room and one of the clients is playing chopsticks on the piano and she said 'Dance for me'. So I just danced around the piano and I thought, 'Oh who would they think is the patient here' [*laughs*].

These concrete examples of doing care distinctly demonstrate that there are a myriad of ways that the social workers who participated in this study put care into their day-to-day practice. While genuine care was primarily seen to be about meeting the needs of the client, building relationships, being there and going the extra mile, it was sometimes necessary to recognise limits to confidentiality and adhere to certain professional boundaries. At the same time it was recognised that often boundaries interfered with and/or negated caring practice, with some participants expressing a disdain for professional boundaries and others a willingness to be flexible when following them. With over half of the social workers discussing the importance of self-care in direct social work practice, it is evident that for many it was difficult to maintain care for others if this was not balanced with caring for the self.

## **Doing Care within Organisational and Political Contexts**

The following section of the chapter begins by presenting the barriers to care that the social workers experienced, as a result of the organisational and political contexts that their practice was situated in. I provide evidence of how participants demonstrated resistance in an attempt to mediate and/or counter the barriers to care that they faced.

## Barriers to caring social work practice

Barriers to care were economic constraints (n=8), time constraints (n=7), risk assessments (n=7), focusing on individual responsibility (n=5), facing criticisms of caring practice (n=4) and personal limitations (n=4).

### *Economic constraints are barriers to care*

Half of the social workers who participated in this study flagged economic constraints as barriers to care in their social work practice. A lack of government funding to meet the needs of clients was seen to be of significant concern to six participants. Mary reflected this view, highlighting the struggles she faces:

They never employ enough social workers to do the amount of work that's needed. I haven't found an organisation where everyone isn't run off their feet because of all the health cuts. 'Prioritising' has become the buzz word and you have to justify what you do and what you don't do and who you choose to see. When I'm reflecting on the work I can't do, I try to think about the good work I am doing, but it doesn't stop me beating myself up about it. All the children are deserving.

Shirley said:

Funding means that our clients are only entitled to 14 counselling sessions. I guess we are only meant to care for a few sessions. If you look at best practice models for treating PTSD that's 20 sessions, so we already don't fit into that. But even 20 sessions; if you are looking at the complex trauma that we are often looking at, people who are really distressed, that doesn't fit into any of those models. It's all about money! Sometimes starting something and not being able to finish it is worse than not starting at all. Also a part of our service is an after-hours crisis service. Sometimes people don't fit the 'crisis' criteria but still need someone to talk to. We can't do that. We are not funded for that and that's a real struggle.

Lou expressed concern about economic constraints when she said:

You have to work within the guidelines and the guidelines can be suffocating. How do you manoeuvre when there is such limited funding? How can we dance and manoeuvre to change peoples' lives when there is no room to do so?

Yasmine shared an experience from her time acting in a social work management role that illustrates the complexities of juggling economic issues with care:

When I was in management there was an expectation that a service would be cut because they didn't feel like there was enough evidence for appropriate outcomes, even though the clients were enjoying it and finding it valuable. I found it really difficult to stay in that place of care when I was dealing with these economic and efficiency outcomes and the arguments were very strong and very logical. It was only in hindsight when we achieved the efficiency that I regretted it. I don't mean we needed to keep that particular service running

but the efficiencies were meant to provide a better service and a more focused service which due to several months later some new cuts coming in never eventuated. When I look back it was the thing that made me decide to not apply for that position permanently.

Yasmine went on to argue that social workers continually have to juggle the competing demands of a client-focused approach that underpins their code of ethics and the economic constraints imposed on them. She explained:

We have a set amount of money and we have to try and have the best outcomes for the greatest number and so we are always trying to work at that interface. It can be too easy to dance to the beat of the organisational drum and think you are doing a good job because you are efficient and effective.

Similar thoughts were presented by Susie as she talked about her belief that economics influenced models of social work practice. She explained:

I think there's an economic rationalist approach within the managed care model that we have seen emerging in government policy. I think there is an economic dimension to the whole idea of brief therapy, where brief is promoted as better, when in reality it is not always in the best interests of the client. I believe in long term care, but not for the sake of it, when nothing is changing. We need to be realistic, but I don't think it has to hold and go the other way where we just provide this amount of work for these people and prune back eligibility criteria.

### *Time constraints are barriers to care*

One of the main constraints on care that social workers mentioned, was having limited time. Susie summed this up when she said:

I guess there's only so much time in the day. That's the barrier to care – giving the clients the time they want. Sometimes when you are really rushed for time it's really hard to show care.

Amber referred to time as a factor that often differentiated professional care from personal care. She said, 'It's different to caring about a friend or family member or a partner when you can devote more time to them'. For Jade, time constraints had a huge impact on her ability to care as she viewed her ability to give time as essential to caring social work practice. She explained:

The most important thing we can give is patience and time but sometimes we just don't have the time. I don't like to look at my watch because they will notice and they will say 'Oh, your time is up isn't it?'. You know – they will say that and say they don't like it.

Yasmine and Mary both spoke about time constraints being largely due to expectations from organisations to meet productivity targets. According to Yasmine:

Lack of care and empathy, I think, is often to do with being time poor in situations where there is so much expectation on practitioners. I think it's always been the case, but even more so now...there are certain levels of throughput of clients expected in some organisations, and in others, just by the nature of the number of people you have to see in a day. I think this constrains what you can and can't do – the amount of care you can provide.

Mary expressed similar views. She stated, 'They [the organisation] give you time slots with no recognition of emails and phone calls to parents, and case notes and admin and planning. It's crazy!'

### *Risk assessments are barriers to care*

Many of the social workers that participated in this study spoke about how the neoliberal focus on risk management created a barrier to care. This included risk to themselves as professionals and their own safety, risk to the organisation and risk to the client. Mary referred to the way that risk was ever-present in her work. She said, 'I don't like that focus on risk and the worry that goes with it... because it scares me and sits on my shoulder'.

Susie told a story about a young woman who had been suspended from school due to bullying and how she wanted to help her but felt restricted due to the focus on risk to other students and staff. She explained:

The school was concerned because the student had hurt other students and the school had concerns around that risk stuff and couldn't predict when things would blow up. They were really mindful of other students and other parents and where their thoughts were around this student. I can understand all of that but where is the care for the young woman? You know, risk ends up overriding everything else.

Billy mentioned the risks he managed, working as a young man alongside young men and women, who could misinterpret care and compassion for sexual or romantic overtures. He explained:

For a young male it is an incredibly vulnerable position to be in a counselling room with a 13 year old girl, disclosing anything and everything. They decide what they want to wear and what they want to tell you about their past sexual history and the whole lot. There is no way you are going to say stop. It doesn't matter if I'm uncomfortable, but then everything else around it needs to be controlled as much as possible. So, touch is completely out of the question, apart from maybe in my boys group I might slap them on the shoulder of something like that. But normally it is a complete no-no. For males I might shake their hand if that's something they are used to doing. But therapeutically I understand how valuable touch can be, and does that get in the way of my

ability to care? Maybe so; but for me I have to actually sacrifice that to protect myself. Yeah, it's very, very frightening, because it's something that could destroy something that is very important to you very quickly, so it's non-negotiable for me.

Lesley and RM suggested that rather than allowing risk to become a barrier to care, the consideration of risk factors was an integral part of genuine care. Lesley summed up what she saw as the pervasive nature of risk when she said:

If the client is at risk, you are at risk, potentially your employer is at risk and the community is at risk: all because you have actually made decisions based on too much heart and not enough head.

Adopting a different stance on the topic, RM spoke about the difficulties involved in deciding what to include in case notes. On the one hand he remained concerned about maintaining a certain degree of confidentiality, aware that once something is written down it could potentially be used as evidence against someone in court and become public property. On the other hand he was aware of the risks of not documenting potentially damning information, including risks to him as a worker and any third parties that may be involved. Therefore according to RM attention to risk ultimately demonstrates care. He explained:

We always have to be careful what we've got in our files. Do we write it or not write it? If it comes out that you haven't written it, why not? There are always dilemmas and if that comes out later and we didn't report it and we let the person deal with whatever is going on and thought, 'Oh, we will just do this quietly', but something goes terribly wrong then that would cause trouble for everyone concerned. You know, you hear about some horrible domestic deaths and then the coroner in the courts will be looking into that. You know it's all that stuff and it's on our back door. So if you really care then you have to document that stuff. It's about protecting me but it's also about protecting other people. Care extends beyond the client. I know when I hear those things I wonder if they could have been a client of ours. You know it runs through my head. It doesn't eat me up, but I think about it.

Participants shared quite different concerns about the impact of risk on care, with some viewing the risk focus as detrimental to care and others believing that consideration of risk factors are a vital part of caring practice.

### *An individualistic focus is a barrier to care*

Five participants referred to the impact an increasing emphasis on self-responsibility

and self-sufficiency has had on service delivery. Kellie shared her thoughts on this, saying:

There is this notion in the current political context and whole idea in our society where it is all about individualism. It's all about everybody being able to take care of themselves, which seems to be counter to that idea of interdependence and relationships. And I guess that's saying something about where our society is headed.

Susie highlighted contradictions in this philosophy around individualism when she stated:

You hear the rhetoric a lot don't you? Services want to see people become not too dependent so they stand on their own two feet; but then there is also that big push from the Government for community development and building social capital and inclusion. There is a big push for that on the other end, so I don't know how those two things meet.

Both Yasmine and Kate added to these ideas, expressing concern that a focus on individualism fails to recognise societal and structural factors that impact on clients.

Yasmine explained:

There are often other forces at play that make it very difficult for them to effect change in their lives and I think it's a requirement for us as social workers to support the person to look at the bigger picture and help them effect that change.

According to Kate:

I run mental health groups with another professional where we talk about the idea of 'participation'. To me the idea depends on the person and their unique circumstances but to her it's about taking up opportunities that the clients are offered and getting quite annoyed when they don't accept referrals or whatever. There is a place for all that but for me it's about that understanding that for some people there are just so many barriers to participation.

Amber held similar views and added:

Often when people are isolated from others in their lives there is a sense of their social worker being a friend, and the social worker can be a friend in a sense for a while. I know that part of my early training was the notion that the social worker is a bridge and I can still remember the diagram of the bridge. It's okay for people to walk over you when they need to for a while. It's okay for you to be the arch that supports people till they get to the other side; it's a temporary thing that helps them get to the other side. There are a lot of people that think that's wrong though, that think it is enabling or promoting learned helplessness.

### *Facing criticisms of care is a barrier to care*

One quarter of participants in this study expressed feelings of being misunderstood or criticised by other professionals for demonstrating care. In some cases this made it difficult for the social workers to care in the way that they wanted. Yasmine explained:

It's very hard when there are hard-nosed decisions to be made and sometimes when social workers are in that mix they are criticised for caring about issues beyond the money. There have been situations where I have felt criticised for raising concerns around decisions regarding resource allocation.

Kate had been explicitly told by another professional that her caring practice was an issue. She explained, 'I was told, "Oh, you just care too much"'.

Kellie shared an experience of medical professionals disrespecting her practice. She encountered a situation where a young woman who had been receiving medical care was distressed and angry. Kellie described what happened next:

I just went over to them and said, 'I'm here, I'm happy to talk to her' and the nurse said, 'Oh no, it's medical, it's medical', and I thought how can a young girl who is obviously distressed not be a human being and have feelings. They think it's all medically focused and often it's not.

Mary and Kate both said that they would use different language around fellow social workers than they would with other professionals, attributing this to their awareness of potential criticism. Mary said:

I would feel more comfortable talking about care and love around other social workers. In my work context which is dominated by other professionals, I wouldn't use those words. They might question whether it is ethical to 'care' for these children and you don't want those tag or labels or doubts.

Similarly, Kate commented:

If I went into a meeting and said, 'I work from a place of love', can you imagine [*laughs*]? Although when I'm talking about my framework to social workers I talk quite firmly about my framework as a love of humanity.

Amber spoke about the way that clients can often be perceived by others as manipulative and attention seeking, instead of in genuine need of care. She explained:

It is often thought that it is about manipulation from the client, but when people are so desperate to have their emotional and other needs met and are crying out, you know, they are just desperate basically and bordering on hysteria. They are alone. How should we expect them to be? What should they do? Who should



they phone? We are talking about desperate loneliness. Who am I? What am I doing here? Extreme loneliness, and often so misunderstood.

### *Personal limitations are barriers to care*

Four social workers who participated in this study mentioned that their own vulnerabilities could sometimes impact on the level of care they were able to deliver to their clients. In Mary's words:

There are going to be contradictions at times when your practice is not going to be your ideal practice. There are times when you are tired and times when other things are going on.

The emotional toll that caring about every individual client and situation can take on social workers was a concern for Ashley. He spoke about the need to protect himself against that:

The reality of this society we live in is that people are going to continue to suffer. It would just become heartbreaking I think if you were walking in these people's shoes with compassion and care on a daily basis I think. You need to put up some boundaries around this so that you can continue to do the job.

Kellie explained that there are times when fatigue or frustration can impede care in her practice. She said:

Every now and then I might be really tired or if a client is being rude to me or something I know the difference between when I'm caring and when I'm careless. So, there's a change, there's a shift. That's not how I like to practice but it has happened every now and again.

Jade pointed out that as human beings with human limitations, social workers cannot always bring about the change that people want in their lives. She explained, 'As much as I would like to make everybody happy and comfortable, I can't provide everything and we can't just turn lives around. We don't have magic'.

### **Resisting barriers to care by taking a moral stance**

While participants revealed that there were definite barriers to caring practice, they spoke about ways that they managed to break through and resist such barriers by taking a moral stance towards care in their practice. Means of resistance included taking a stand (n=11), bending the rules (n=5), picking battles (n=5), justifying care (n=5) and taking risks (n=4). I begin by reporting how the social workers resisted barriers by taking a stand.

### *Taking a stand for care*

Three quarters of the participants in this study referred to ways that they defended their ethical frameworks of care in order to meet the rights and needs of their clients. 'Taking a stand' included challenging policy, colleagues, other professionals and management. Jade explained how her commitment to her clients' needs informed her practice:

With a multi-disciplinary team we have conflict because they will say, 'No, we don't need this because of this', and I will say, 'We need to do this, because of this'. So, I have to push and be there and be consistent but make sure that it is the right thing. Basically, if it is the right thing I have to be consistent and say it again and again and again. I won't give up when I know something is just wrong.

Kellie shared this view. She said:

Care is the foundation. You know you still have to do your job and still conform to the organisations protocols but at the same time certainly fight for care, which I think we all try to do here in different ways.

Cloudy Bay spoke about how he had taken a stand by challenging others in the workplace. He explained:

A classic example is that we have had another professional in the organisation who talked about empathy and capability and respect and care and all that, and he behaved in completely contrary ways to the point that he would be abusing colleagues. So, you know, I took it to task on a couple of occasions. It didn't actually change him, but it certainly moderated his behaviour and made him realise that he had to monitor what he was doing.

Challenging government policy that was viewed as uncaring, was something that a couple of social workers mentioned. Sally referred to a situation that occurred several years ago in relation to policy around payments for funerals. She explained:

This policy stated that somebody who had nobody to take care of their body, no family etc is entitled to x amount of dollars for a cremation. The deceased person that I was looking at this for was from another culture, another country, where you absolutely cannot burn the body, you cannot burn the body. That goes against every single thing they believe. So this policy was incredibly outdated and didn't reflect our more changing times when we have people in our own communities from other cultures...It was discriminatory in a religious sense. So I produced arguments and what I asked for was that the money that would go for the cremation be put to this person's funeral and then the community would find the balance that was owing. They wouldn't even do that. So, what happened was that a whole community of people paid for it, a lot of money, so that this person could be departed in a very, very respectful and culturally appropriate way for them. Now, this made me sick, what was happening with this policy. I couldn't let go of that and I knew how distressing this was to many people. It put a whole community of people into angst and pain. I thought, 'Right! I have to do something about this – I can't let it rest'. I

kept going up and up the ladder and kept being annoying, and now the policy has changed. Yeah, it is now inclusive of other cultures and beliefs.

A significant part of Shirley's role involved standing up for clients who had been victims of sexual abuse. She believed that often the focus on collecting evidence and putting a case together superseded basic care. She explained:

They might be at the hospital and we have got the forensic nurses saying, 'We have to do a forensic examination and we have to do that to get the best evidence'. We have the police saying, 'We have to get the best quality statement and we need to do the investigation in a quick and timely manner'. Then there is this person who has just survived and my work is not based on what the police think is best or what the nurse thinks is best, but what the person needs right now, how they are going to get through this moment to be able to make a decision about what they want to do – if they want to have an examination or talk to the police or if they just want to go home, or whatever it might be. It's about what that person wants and needs for them to be able to harness whatever power that they feel that they have left. I get so much crap, you know, from police. They will say, 'Don't get involved', because it might stall the investigation and that kind of stuff.

Three participants mentioned standing up for clients when overhearing conversations in the workplace that were disrespectful to the client or undermining confidentiality. Susie explained, 'Sometimes I've had to say, "Look this conversation is disrespectful, we need to stop talking about this family"'.

Lesley commented:

I guess the point is that part of our ethical stance is that if we hear people talking in the tearoom and say 'Oh this bitch did this, you wouldn't believe it' we need to say something. Occasionally it is really useful to say, 'Hang on a minute! I know to you they are a pain in the arse, but, can you imagine what that person is going through?'... You know, these people deserve maximum respect regardless as usually they are being resourceful and doing a fabulous job in spite of whatever else is happening. They deserve respect rather than being treated like an idiot. So, sometimes you have to say, 'Hang on a minute, can we just stop? You are being really unprofessional when you do that'.

Sally supported these views when she stated:

In terms of care I believe I have a responsibility to challenge that stuff and not participate in any sort of conversation of a nature that is derogatory to other people.

### *Bending the rules to remain care-focused*

One third of social workers described practice situations where they prioritised care above the adherence to rules and regulations. Amber provided the following example:

There have been some things that have been on the edge of rule-breaking that I might have been expected to be called to account for. For example, I might accompany someone to hospital when they haven't had any family or friends to do so. I will think first, 'Is there any other possibility?'. If there are no other resources and I am able to do that and if I think it's safe to do that, then I will do things like that. If it is going to move the situation to a better situation than it is now, I will. That's kind of my rule. But I have been fairly fortunate – I haven't been called on it yet.

Cloudy Bay shared the following story:

There was a client staying in the organisation and he had brain damage from alcohol and lost all autonomy and didn't have any hope for the future. It was really sad. He was hungry for a fag and the service is a no-smoking zone and certainly social workers never go and buy cigarettes. But this was the last bit of autonomy and control over his life and he is going to have a short life, so in the scheme of things it's not going to make any difference. So, I went out and brought him some cigarettes. Most of the staff were great – they got it. I got a lot of stick from one colleague, saying, 'This is against policy, you shouldn't be doing this'. I said, 'You are probably right, but from my judgment, for these reasons I did it'... I have a pretty healthy disregard for rules. I like to see them as guidelines.

Billy managed to 'bend the rules' for one client around accessibility to the service.

He explained:

There was this young guy who had a horrific background with a history of trauma who came in for three or four sessions initially and then disappeared. He would come back and book 10 appointments and attend only three or four and then book more and not attend any and then come back and attend a couple – that sort of thing...the books were meant to be closed. The organisation has a policy around 'did not attends'. If someone doesn't attend after a lot of follow up and options to fit in appointments and stuff, then the file is closed. I should have closed him 17 times by now, but I have kept him on the books, just so that if at any time he comes in, then we can just keep going. I mean, he does come back and he will come for three or four sessions and we will get the next stage done, and so we do it in bits. You know, I think he does well to come at all when I consider his background and so I am not going to make things even harder for him.

Several social workers voiced ways that time constraints can be managed in a way that ensures care is maintained. Yasmine argued that social workers who are committed to care 'find a way':

I've seen workers being swamped with clients and administrative duties find a way. They have become really creative in trying to find ways of managing that increasing gaze of government departments and the emphasis on efficiencies...they have still managed to stay true to giving people they work with time and to care and connect...I mean if you really have very limited time you can create that same connection and empathy – you can do it in five minutes. You can be compassionate and respectful and use the time you have to show that care. I don't think efficiency and evidence based pushes from managers prevent you from being caring. For the sake of perhaps a five minute conversation it might be about saying something like, 'Is there a possibility you can come back tomorrow?'. I think it's really important to let them know that you do want to see them. They really appreciate that they at least feel acknowledged.

Jade took little notice of time limits, believing them to be counterproductive to caring practice. She said:

I've always told my team that I am a social worker and my interventions will be different. It is not going to be five minutes or 10 minutes. If I take a long time it's because that's what the client needs and I won't compromise their care.

### *Picking battles*

While participants were committed to 'taking a stand' and 'bending rules' in the interests of enacting an ethic of care in their practice, several social workers explained that they felt the need to pick their battles. Lou said:

It's hard when you are the sort of social worker that does like to make waves if you need to or challenge things if you need to. That's hard when you're trying to be accepting and have good relationships with your colleagues at the same time. So, I think it comes down to picking your battles.

Being respected by her colleagues and management team and showing respect to them in return was important to Kate and for that reason she chose to pick her battles. She explained, 'I pick my battles. That's something I learned straight away, that if you want to be respected and listened too, you really need to be respectful'. Sally said that she also tended to pick her battles and explained that it is when the clients indicate that they are being treated unfairly that she will always stand up for them. She commented:

When I think about it, I don't fly off all the time. It would just be too difficult and tiring. Usually it is because the client group has told me it's wrong. They tell me that and if they me something is not ok, I will change the way I do things. If the organisation wants to sack me, let them try.

Lou went on to explain that she had learned to let some things go, as constant conflict had proven to be counterproductive, however, when she felt others were

being treated as unimportant she would speak out. She provided the following example:

We had a guest coming to speak to our parents group and they told us the time, two o'clock on a school day. To begin with I thought, 'How stupid, what's wrong with 10am?' So, what happened was, the speaker realised she had forgotten our meeting and the parents were there at two, waiting for the person to turn up. No apology was made... they were treated as if they had nothing better to do and just told they may as well go home. I know these things can happen, but it was the way they were treated as if it wasn't a big deal when to them it was. I went into our supervisor and said, 'I'm really pissed off about this, this is disgusting'. I do lose it sometimes. If there were consequences for telling the manager I was really pissed off, then so be it. So, when it's big – when I'm thinking this is not right, yeah, I will stand up.

Cloudy Bay believed that it was only worthwhile fighting for something when there was a possibility it could make a difference. He explained:

You probably pick your battles. I realised I was never going to change the federal agenda on a certain issue so I just walked away. I tried for a while, but then realised that I was wasting my time, time that could be making a difference elsewhere.

When Billy was asked why he chose to pick his battles he explained that if he challenged every decision and every policy then everyone would get sick of him and take no notice when something really important came up. In his words, 'Oh, well the boy who cried wolf ends up getting ignored and they end up thinking. "Oh that whinging guy is at it again"'.

### *Justifying care*

Many participants argued that while it is important to resist the barriers to care in their practice, it is also important to be able to justify decision-making and subsequent actions. Justification was seen to ensure credibility in the eyes of others as well as providing confirmation to the workers themselves that they were making the right decisions. In many cases social workers used the ethic of care to provide justification. According to Sally:

I think we need to be very accountable for our actions. We need to have a very clear and developed process that works and then we can justify it. My practice framework is very solid and I am very comfortable with it and I can use that to speak up about injustices and ethical issues.

Kellie believed that it is important to explain the way she works to other professionals. She explained:

We need to advertise ourselves more and use every opportunity to tell other professions what we do and why. I think that helps them understand, so they know and think, 'Ok, that actually worked', and they can see it as practical and evidence based and it becomes more credible. I try and feedback outcomes as much as I can, so they get to know that what I am doing is important.

Similarly, Lou commented:

One thing I have found is that I need to explain my actions and justify why I'm doing what I'm doing. It is such a traditional organisation and sometimes I have to try not to lose my temper because it all seems so obvious to me, but that helps them understand.

Mary believed that her practice framework of care gave her the means for justifying her decisions. She explained:

Just knowing you can justify care with a formal framework and language really helps. Sometimes other people don't really know what to say when you are using language of care and ethics and talking about 'doing good' and 'doing right'. Usually they will just look at you and go, 'Ok, yes, yes'. Even if they don't get it, I guess it sounds good [*laughs*].

Kate had learned to protect herself by thinking about how she would justify certain actions. She said:

There was something that happened last year where I guess I didn't really follow the rules. I remember somebody coming up to me and saying, 'You could get into a lot of trouble for doing this'. I guess I had to take that away and think if I was questioned about it why I actually followed through. So, I guess that's what I make sure I do now.

Mary explained how she would often refer to the Code of Ethics to assist her in justifying caring practice. She said:

I don't think the Code of Ethics talks about care as such, but it does talk about respect and justice and self-determination and all of that, so it helps back up my decisions when I need to justify something. It was my ethical bible when I was a new grad.

### *Taking risks*

While risk was considered to be a barrier to care, several participants spoke about taking risks in their practice as a way of enacting care. This involved challenging the pervasive attention to risk management that dominated organisational policy and protocols. Susie was working with a teenage girl who had bullied her peers and was

generally enacting 'risky' behaviour at school. This led to the girl being temporarily expelled, followed by restricted attendance at school. Building a relationship with both the girl and the girl's mother, assisted her to understand the difficult home life and significant trauma that had been experienced and provided some context to the behaviour. Susie explained the risk she took in advocating for the student:

I just felt my role was around trying to advocate for that student and increase her time at school. As much as I could see where the school was coming from, you know, it's not ok for her to beat someone up but I didn't see how ostracising her was going to help. I was thinking about the stigma she would live with and she deserved another chance, with lots of support to help make sure it didn't happen again. What about the risk to her? I guess that's where that ethic of care comes in – or the ethical side of it... I organised a transition program with the high school, where she would be going the following year. It all worked out really well, thank goodness...it was risky I suppose, but I just felt it was the right thing to do; I had to do what I could.

RM pointed out that risk factors are often uncertain and complex and at times following standard risk protocols can cause unnecessary harm and suffering. He believed that organisational policies around risk are sometimes more about protecting the organisation and the worker rather than the client. He provided the following example from his practice:

Someone said to me, 'Look, I hit my child. I know I shouldn't have done it, it's not something I believe in, but I was desperate. It wasn't just a slap, it was a bit more than that, but I was desperate. It doesn't fit with my values – I'm telling you because I'm shocked it happened'. Then I thought, 'Should I do something about it? Policy would say I should'. I thought, 'Well, what are the values of the parent?'. If the parent had thought it was a good idea and believed in it, then, yeah, I would have reported, but it was a one off and I really didn't see that reporting was the answer. If I only cared about covering my own back I would report to make sure I was covered, but that would have been awful for the client in this situation. If we take it out of context one should always report risk and harm, but it's rarely that black and white.

Taking risks was considered stressful for practitioners, as highlighted by Mary when she spoke about a risk she took in her practice that resulted in her experiencing considerable stress and anxiety. This is the story she shared:

A child asked me to write a letter of support to his lawyer who was handling a family law case regarding the child's father. I think I knew that it was risky and out of the norm and it didn't particularly put the father in a positive light. I told my direct manager and asked if he wanted to see the letter and he said, 'No, I trust your professional judgment'. Anyway, the father did not like the letter and made a complaint. The letter went to my managers and directors and it went to the state director as well. The letter was scrutinised sentence by sentence. At the time it freaked me out, wondering what they were saying and what would happen. On reflection I would probably do it a little bit differently but there are



only slight things I would change, but overall not. My gut told me it was the right thing to do, you know from an ethic of care and doing good and what is in the best interests of my client. It did help my client and that's what really mattered.

## **Concluding Comments to the Chapter**

In this chapter I reported that the social workers who participated in this study enacted care in their practice in a variety of ways. It is evident from the examples provided, that care was driven by a sense of moral responsibility towards clients, a genuine concern for wellbeing and quality of life, and a desire to relieve suffering. It is also apparent from many of the stories, that the participants considered issues of justice along with care. Care did not negate attention being paid to fairness. Participants found it difficult to care at times, due to the barriers posed by organisational, political and professional contexts, yet they often found creative ways of overcoming these difficulties. While the means of breaking through the barriers varied, a commitment to upholding a moral standpoint towards care often drove resistance to organisational ideologies and constraints. It is evident that this standpoint informed the caring practice of these social workers. This concludes the presentation of themes identified from the social workers who participated in this research. The experience of care in direct social work practice from the perspective of social work clients who participated in this study is presented in the next chapter.

# **Chapter 7: Experiencing Care – The Client Perspective of Care in Direct Social Work Practice**

## **Introduction to the Chapter**

In this chapter I present the crucial client perspective on care in social work practice. Participants of this study offered their views and shared their experiences of being on the receiving end of both caring and uncaring practice. Clients who participated in this study responded to interview questions that enquired about their perceptions of caring social work practice and examples of caring and uncaring interactions. I begin this chapter with a profile summary of social work clients who participated in this research, followed by a summary of the main conceptual themes and sub-themes presented in this chapter. I identify four main themes from the interview data. The first of these is ‘experiencing care as being valued by social workers’. Feeling valued assisted the clients who participated in this study to value themselves. When clients felt that they were treated as an individual, experienced presence and gentleness, and felt that they were believed by social workers, they said they were more inclined to feel valued.

The second main theme, ‘experiencing care through connection with social workers’ is discussed with reference to empathy and compassion, deep listening, and trust, which proved to be important components of forming positive relationships with social workers. Ultimately, the ability to connect with social workers assisted clients to feel cared for and to engage in a caring relationship. Next, I explore the third major theme, ‘experiencing care by social workers as paying attention to needs’. This theme highlights care as recognition of needs, attending to ‘the little things’, providing options and guidance, paying attention to practical concerns and following up. The chapter concludes with the final theme, ‘reflecting on the importance of care in social work practice’.

## Participant Profile Summary

Table 7 presents a summary of key characteristics of all social work clients who participated in this study, including the pseudonym chosen by participants and their gender and age. As indicated below, of the 15 participants, eight were male and seven were female, and their ages ranged from 21-77 years of age.

**Table 7: Participant profile summary of clients**

Pseudonym	Gender	Age in years
Alex	Female	22
Archibald	Male	21
Bob	Male	28
Chris	Male	25
David	Male	24
Emily	Female	32
Emma	Female	42
Eve	Female	49
Jessie	Female	22
Luke	Male	31
Margaret	Female	77
Nicky	Male	26
Pink	Female	45
Red Devil	Male	49
Scott	Male	30

## Conceptual Themes of Client Experiences of Care in Direct Social Work Practice

Table 8 provides a representation of the themes that emerged from the analysis of the data from the social work clients who participated in this study. This table also provides a map to guide the reader through the chapter.

**Table 8: Conceptual themes from clients' experiences of care in direct social work practice**

Experiencing care as being valued by social workers (n=43)	Feeling valued by social workers		n = 15
	Being treated as an individual by social workers		n = 10
	Being believed by social workers		n = 10
	Presence/gentleness displayed by social worker		n = 8
Experiencing care through connection with social workers (n=43)	Empathy and compassion of social workers		n = 12
	Deep listening by social workers		n = 10
	Trusting social workers	Building trust with social workers	n = 11
		Genuineness and honesty of social workers	n = 7
		Social workers maintaining confidentiality	n = 3
Experiencing care by social workers as paying attention to needs (n=28)	Social workers recognising needs		n = 6
	The little things that social workers do		n = 6
	Social workers providing options and guidance		n = 6
	Social workers addressing practical concerns		n = 5
	Social workers following up		n = 3
	Constraints on social workers doing care		n = 2
Reflecting on the importance of care in social work practice (n=15)			n = 15

## Experiencing Care as Being Valued by Social Workers

Throughout the interviews, client participants identified care by the degree that they were made to feel valued through the attitudes and the general demeanour displayed by social workers. The sub-themes identified from this main theme included feeling

valued by social workers (n=15), being treated as an individual by social workers (n=10), being believed by social workers (n=10), and presence/gentleness displayed by social workers (n=8). I begin by presenting the findings about feeling valued by social workers.

## **Feeling valued by social workers**

All 15 clients who participated in this research implied that being valued was a key feature of experiencing care in a social work interaction. Care was implicit in many of the features that they talked about, including being listened to, being believed, non-judgment and having confidentiality upheld whenever possible. Six participants overtly articulated the importance of ‘feeling valued’ in caring practice. According to Emma this was the most important sign of a caring social worker. She said, ‘The best thing a social worker can do to show they care for you is to help you feel more equal, to feel valued’. Alex echoed Emma’s view explaining that:

Some special acknowledgment and acceptance of me – that’s what makes an outstanding social worker. Making you feel important, even in the smallest ways is sometimes all you need.

Jessie explained that feeling valued was empowering. She said:

I don’t know why, I don’t know why it matters what they think about you, but it does. Yeah – it can make all the difference to how it all goes. It’s like you are not just a victim; you are a worthwhile person and it makes you start believing in yourself. It puts you in a brave position.

Pink provided an example of feeling valued by her social worker when participating in group work. She explained:

As we are leaving the group she says goodbye to each of us and gives us a couple of minutes. She asks us how we went with the session and if there are any questions. She sits back and if you want to have another coffee with her and you want to sit there, she has those few minutes before she has to go. I know she is very busy and hard to find sometimes, but that it is because she is doing it for everybody and cares about everybody.

Some participants described feeling valued as being treated as if they really mattered. Emma had seen a hospital social worker prior to having surgery. She was extremely nervous about the surgery due to previous traumatic experiences with medical professionals. The social worker was very supportive and understanding and helped Emma to face the imminent surgery. The morning after the surgery, the

social worker visited Emma in hospital, an experience that Emma found memorable.

Emma explained:

The next morning she started work early, so that she could come and see me. She didn't check her messages before she came, she came straight to me. I didn't go into much detail because my dad was there, but I thanked her so much and said it was because of her that I felt safe. She was lovely! She gave me a hug and said she was so pleased I was ok. It was great and I felt that I really mattered to her.

In contrast Emma had received a negative experience from another social worker who made her feel that her own knowledge as a mother was devalued and disrespected. Emma's daughter had been home schooled for a while due to difficulties she had been experiencing both mentally and socially. Emma explained that while the social worker appeared to be very caring on the surface, her actions left Emma feeling disempowered and undermined:

Even though she appeared so caring, so caring and lovely, one of the loveliest women I've met, she took my power away. If I had used my voice it would have looked like I was putting my daughter down, with her there in the room, and I couldn't do that. The social worker said she needed to be at school full-time for social reasons, but I know from all my reading that mainstream school is not always the best for these kids. I also know my child. You know, I could have managed what happened if she'd gone part-time, but that wasn't how it went. She is now full-time and it is really difficult. Her marks have gone down and she is exhausted all the time.

Several participants had experienced times when they believed that the social worker valued their own agenda and needs above the client, resulting in the client feeling devalued and uncared for. Eve spoke about the uncaring way that social workers often approached discussions about suicidal thoughts and intentions. In principle she understood that supporting a client to consider strategies that would help avoid suicide attempts was important. However, she believed that all too often it seemed social workers were more concerned about the repercussions and the guilt they would face if a client ended their life, rather than genuine concern for the client. Eve was clearly angry when she explained:

The suicide contract – it is just pathetic and usually doesn't work. They do the whole, 'Oh, you're contracting with me that you won't do this', and I just think, 'Oh please, just put some more guilt on top of me'. You can tell when they are more worried about themselves and covering their own back than about me. Then if you ring them when you are in a bad space, they are like, 'What are you ringing for'. They are full of shit... I don't know how many times I was suicidal and I actually had to manage the social worker's discomfort.

## **Being treated as an individual by social workers**

Two thirds of client participants spoke strongly about how being valued required being treated as an individual rather than ‘like a number’ or a ‘case’. Red Devil explained, ‘I hate being treated like a number... You need to be listened to and valued as an individual’. Alex also believed that being valued required being treated as an individual with unique problems. She said:

Lumping people all in the same box isn’t helpful...treating people like a number, not a person. I hate that and that’s what happens when they just tick boxes. They don’t find out about you.

Archibald echoed these comments when he stated:

It is important to put an effort in to get to know me. Yeah, treating me like I am an individual, not just treating me like another person with the same problems – you know, just like a case, just like a number.

Margaret stressed the value of being treated as an individual in these terms:

I think I speak from the experience of a really wonderful social work experience, because I wasn’t just a number, I wasn’t just a person who came in and it was a routine process. It was something quite special really and I think that’s why. If you can get social workers who can make experiences like that special for people, then you touch them and you don’t know how far that goes.

## **Being believed by social workers**

Ten participants said that being believed helped them feel valued and in turn indicated care. Eve spoke about a time when she was facing a custody battle after losing her children to her ex-husband. She had faced abuse and was very concerned about possible violence being inflicted on her children. She explained that no-one seemed to believe her or take her concerns seriously until she met one particular social worker. She talked about how he was different to the others:

He saw that I was being truthful and he just listened and he was solid. I think of him now and I see head and shoulders there, a level head and he could see what was going on. He could see the realness of what I was saying and didn’t ask me ridiculous questions about my own worth as a mother. He cut through the crap and supported me completely. He was awesome.

Jessie shared a positive experience she had where a social worker believed her, in spite of concerns that she would not. During her adolescence, Jessie was living with a family who took in homeless young people. This was not a formal foster family situation, but rather a family Jessie had heard about through informal conversations.

She and some other young people experienced abuse at the hands of one of the ‘carers’, including harsh punishment when they did not ‘toe the line’. She explained:

Things had happened in the family I was living with, absolutely awful, awful things and I thought no-one will believe me and no-one will think it matters, but I thought I will just try. When I told her she was like, ‘That is so wrong and should never have happened to you’. The fact that she believed me and what had happened to me mattered to her gave me courage and hope that someone else would believe me. I felt brave enough then to make a police statement about it, and even though they couldn’t really do anything, they did speak to the family about it.

Jessie elaborated by highlighting that such small things can mean a great deal.

While no charges were laid in this case, her concerns were at least validated. She said:

You know, it wasn’t the biggest thing in the world because there wasn’t enough evidence for them to be convicted of anything, and because we were all officially adults it wasn’t a child protection issue, but something happened, something happened! The social worker did believe me and did try to do something... She made me feel I mattered.

Red Devil described his reaction to not being believed. He was adamant that he would no longer work with a social worker who did not believe him. He commented, ‘You know some people don’t seem to believe you. So, social workers like that, I just say, “See you later”, and walk out the door’.

## **Presence/gentleness displayed by social workers**

Participants frequently spoke about the general manner of their social workers.

Expressions of a gentle, calm presence, understanding and patience assisted them to feel valued and demonstrated their care. Emma described the demeanour that helped her feel cared for, as follows:

Their manner needs to be appropriate and if it’s not then I perceive that as uncaring. I think for me caring in social work practice is gentleness. That’s really important. Also making eye contact and just conveying that feeling that is saying, ‘Well, you are here to see me and I am totally here for you’.

Emma proceeded to describe an experience she had with a social worker where she did not feel this gentle manner and the significant impact it had on her:

When she greeted me she was so chirpy and cheery I actually couldn’t stand it. I was feeling really stressed and really traumatised, so I was not in a good place when I saw her. She was just so friendly and cheery that it was like there was this expectation that I had to be friendly and cheery. I just didn’t find that



helpful. I think I would rather someone who was just caring and calm rather than this high pitched overly happy voice. I can't fault what she said or anything, but it felt off. I felt like I was going to talk to someone about a birthday party I was having. For me that over the top manner closes me down as I feel that I have to be all happy for them when I'm not. It didn't feel caring at all.

Margaret shared a similar sentiment when she said:

It's hard to put words on what makes a social worker caring, but it's not being floaty, airy-fairy and not being pushy. It's about being centred and present, really present – and that presence doesn't come from the head, the mind, it's far more than that. It comes from the heart and it comes from someone who is quite balanced. It is about being calm and centred. My social worker is just very quietly spoken, very prepared to be fully present.

Eve explained that it was often possible to tell if a social worker's care had diminished simply by noticing their demeanour. She commented:

They get tired like the rest of us and you just get this impression that they think, 'Oh God, you are still here and you're still working on this stuff'. And I think, 'Yeah, but I'm working on it alright and it's ok for you, you're the General on the hill, I'm actually at the coal face here. I'm chipping away and it smells completely different mate when you're down here'. When I get that feeling the connection goes and I don't want to work with them anymore. I feel like they can't really be bothered with me, that I am just a hassle. I am probably being really harsh but that's how powerful those subtle things can be.

Jessie found it difficult to put into words how she knew that somebody cared, describing it as a feeling. She said:

I'm not into auras and all that, but just the general feeling that I get from her – it is very positive. You know how some people just come across as warm and kind. It's just a general feeling.

## **Experiencing Care through Connection with Social Workers**

Clients considered that care was evident when social workers had a strong ability to connect with them. Empathy and compassion (n=12), deep listening (n=12) and trust (12) were identified as the most important aspects of forming connections between social workers and clients.

## Empathy and compassion of social workers

Being shown empathy and compassion were considered important signs of care by three quarters of the client participants in this study. Jessie explained how she knew her social worker was empathetic towards her:

When I've told her something really serious she doesn't just go, 'Yeah, thanks for that', and write it down. You can kind of tell by her face that she feels sad about that too. She's not just like, 'Ok, so this happened on such and such a date'. You can tell that she has felt it as another human and it affected her. It matters to her.

Eve explained the powerful influence of genuine empathy in creating a connection between herself and the social worker:

One thing that has really helped me feel cared about is her empathy. That's pretty huge. The first time we talked about some heavy-duty stuff she actually cried, and I couldn't believe it. I was just like, 'Are you alright', and she went, 'Just don't worry about this, this is just me', and I thought, 'Oh, I love that, I love that'. The worst thing is somebody just going, 'Aha, aha'. I have done counselling myself, so I know all that reflecting back and all that, but I just thought, "God bless you", because all this stuff about transference and not getting close to people drives me crazy.

Bob, Emma and Luke also commented on the value of empathy and compassion as follows:

Care is about being empathic and compassionate. They are the main things (Bob).

Empathy and compassion are really important because if I don't get it I don't feel cared for (Emma).

Compassion, yeah, that's the thing that really shows me that my social worker cares. She feels for me and understands, but not in a patronising way (Luke).

Alex shared two stories that she believed demonstrated a lack of compassion. The first involved a hospital social worker. Alex had taken herself to hospital with a lung infection. She was having trouble breathing, was treated by the medical staff and then told she could go home. A social worker was called because Alex was upset and had no means of transport to get home. She was appalled at the lack of care and understanding she received from the social worker. She explained:

I couldn't afford a taxi home and it was night time and she said, 'You should have money put aside, how do you live like this?' I got really angry and said, 'I'm poor you stupid cow, I can't afford taxis like you'. I was so angry. The thing that gets me the most is that they are supposed to help and they let you down.

The second story occurred at Centrelink. Alex was seeing a social worker about her inability to work. She was made keenly aware of the unequal nature of the relationship between herself and the social worker in terms of privilege and she also felt betrayed. She described the interaction as follows:

I went through papers and papers and had a doctor's letter to prove my illness and she just turned around and said, 'Well none of that matters, I think you are fit to work, I think you need to have more confidence in yourself'. She just had no compassion or understanding of my circumstances. I thought, 'Yeah, yeah, you and your shiny Volvo and your fancy clothes and full cupboard at home - you can say all this'. For those of us who can't get a job, can't handle a job, not being the least bit compassionate is so not helpful. It's kind of like going to Robin Hood and getting deceived by the sheriff pretending to be Robin Hood. They end up robbing you.

Emma believed that a social worker's ability to demonstrate compassion can be determined by their reaction to crying. She said it is important to feel free to be able to cry without feeling judgment or discomfort. She explained:

If you start crying and someone just sits with you in a lovely gentle way and doesn't feel uncomfortable with that, you know that they are a compassionate, caring person. If you start crying and they say, 'Why are there tears, what are the tears about?' it makes you feel uncomfortable and as if you need to stop to make them feel better.

Several participants argued that just having someone there for them at times showed empathy and compassion. According to Scott the best thing about his social worker was that he knew that he was always there for him. He explained:

I know he will always talk to me if he can when I call and will come and see me when I need him. I've got his number in case I need to call. I know that if he can't talk to me when I call he will get back to me. Sometimes when he comes to see me it's hard to talk, but it's nice just having him there, just sitting with me. It is reassuring. I can tell he is a compassionate person.

Others spoke about how it was not always necessary for social workers to be productive. They said that sometimes all they needed was for their social workers to 'totally be there', to 'hold a hand' or 'just listen'. Jessie worked with a social worker who would spend time teaching her to do craft work. Jessie explained that this was a lovely thing to do when she did not have the energy or emotional capacity to talk about her problems. She commented:

She would just let me be, but I knew she was there for me whenever I wanted to start talking. She didn't push me though because I knew she had that compassion for what I was going through. None of your friends want to hang out with you because you are no fun. So, when that person did that with me it kind of felt like there was still a way I could be with them even though I

couldn't manage to talk. I felt a lot less isolated. Also, because I was doing something, even though it wasn't to do with my problem I felt like I was moving forward, even just a little bit. I was not just staying stuck.

## **Deep listening by social workers**

Twelve of the 15 client participants in this study believed listening to be a key indicator of caring social work practice. Luke found that simply being able to open up to somebody for the first time in his life and feeling that he was being listened to in return was the catalyst for change in his life. He explained:

There was just so much bottled up inside me that I had never talked to anyone about...My parents were drug addicts, a lot of family violence and so I don't talk to my dad. My mum is a mess and so is my brother and so there is not really anyone I can talk to... It's not the sort of thing you want to tell your friends about. Now I can just sit and talk and get it all out. Just being able to do that has helped me so much. It's crazy huh? Something so simple as sitting down and having a chat and having someone listen and understand me. Just that has made so much difference to my life.

Emily also commented on the value of listening. Having the opportunity to share her problems and feelings in a confidential setting was important to her. She said:

My social worker shows interest in talking about what's on my mind. She lets me get it all out if I'm upset about something and I don't have to worry about it getting back to anyone else.

It was evident to Emily when a social worker was not listening. She explained:

You know, you can see them drifting off and they interrupt me a lot.

David felt that not paying attention to what the client is saying is an indication of an uncaring social worker. He stated:

If they don't care, they don't listen properly. It's one of the first signs to me whether they really care about me or not. Some are too interested in their job, in being important; too possessive and controlling of you.

Several participants spoke about how listening assists social workers to understand their situation. Jessie talked about a time when she had run away from home, driving alone with only a learner licence. She felt that rather than showing understanding and concern, the social worker contributed to her distress. She explained:

I was really upset and trying to tell her what had happened, why I had left. She insisted that I go home, but that was not an option for me. She kept saying, 'I'm sure your family loves you, you should go home'. She had no idea! Social

workers are meant to listen to you and help you figure out what you want and what your options are. I was too upset to make her listen. She didn't seem to care, and didn't seem prepared to listen, so I didn't even really want to talk to her.

Eve commented:

Listening is a skill: listening and allowing that person to have space to talk. Everyone knows their own truth: they all know what's best for them and sometimes it's just a matter of allowing them to talk and laying it all out. Like, it all gets tangled up in the silk bag in your head and just separating things out can help you work out what to do.

Alex had experienced times when she did not feel listened to. She explained:

There have been times when I really need to talk about something, something important to me, but it's obviously not important to them. They would say something like, 'This is why we are here and this is what I'm paid for'. You know, a straight road sort of thing, and life isn't a straight road. Putting us into boxes is restricting and we don't get to the important issues we need to discuss.

Archibald connected patience to listening. He said:

I notice sometimes social workers have patience with me when I am struggling to say what I want to say.

Eve believed that social workers need to realise that healing from emotional pain does not happen overnight, even with the best therapeutic intervention. She shared the following experience and explained how when a social worker tried to rush the process it proved to be counter-productive, leaving Eve feeling misunderstood and angry:

I had a social worker who got really frustrated with me because she wanted outcomes. She couldn't understand why the healing process was taking so long. I thought, 'I'm sorry, I had abuse as a child and then ongoing after that for at least 36 years, do you really expect it all to just go away in a few weeks'. To get to where I am now, it's taken a lot, a lot of support, a lot of working on myself and a sense of humour. If she had spent more time listening to me rather than worrying about outcomes and been more patient then it might have been more helpful.

## **Trusting social workers**

Trust was spoken about by client participants in three main ways, these being, building trust with social workers (n=11), genuineness (n=8) and social workers maintaining confidentiality (n=3).

### *Building trust with social workers*

Jessie explained that a caring social worker will understand that it takes time for clients to trust and will work with the client to help that happen. She shared an experience she had with a Centrelink social worker:

I was a little bit scared at first. When you go there it feels like, well it's all about whether you get paid or not and that creates a different dynamic, because getting paid is really important. I was a bit suspicious, but the social worker was really on the ball and tried really hard to help. She went out of her way and spent more time with me than I expected. She was really compassionate and understanding and so that helped me to trust her.

Luke commented:

It takes a while to feel comfortable and to trust. You know, you need to get to know them and feel that you won't be criticised or judged. My social worker is really good though. I tell him a lot of stuff I have never spoken about to anyone because I can trust him.

For Margaret, trust was one of the most important things. She said:

If I can trust them, then that makes a big difference. There are not a lot of people that I do trust, but if I trust then I feel safe.

Eve believed that social workers need to know how important trust is to clients – that trust can be broken in an instant. She relayed an experience from a past social work interaction:

It took a year of trust building with this particular social worker, and one sentence, one sentence was all it took to break that. It was about her stuff. It was nothing about me; I knew that and I understand that we all have those bad days, but if you have a bad day, perhaps you ring up later and apologise and explain. She didn't do that. I got up and walked out and never went back.

In contrast Eve stated that she implicitly trusts her current social worker. Like Margaret she equated trust with feeling safe. Eve explained:

It's a safe place for me to land and I think having that alone can save your life.

Four of the client participants interviewed had primarily worked with social workers who were supporting them for mental health reasons. These participants found it particularly difficult to trust. Scott explained:

I don't really trust anyone. I don't really open up to my social worker because I have been burnt before. I mean, he is really good, but you know, I don't really trust anyone...I don't want to end up in hospital again...I never sign anything if I don't know exactly what it means.

David chose to not have the interview for this research recorded, in spite of being told that only I would have access to the recording and that it would be kept in a secure place. It became clear that this was a trust issue. He said:

I would rather not have it recorded. I am happy to talk to you and you seem really nice and you can write things down, but you know, I would just rather not. I would rather not have a tape with my voice on it hanging around.

For Nicky, his willingness to divulge personal information depended on his impression of the social worker. Past experiences of being admitted to a hospital mental health ward had made him very wary of speaking to social workers about his symptoms and feelings. He explained:

Sometimes I choose not to talk about some stuff because it's a bit personal. It's really hard with mental illness, because often people just don't get it. So, it depends a bit on the person. If they seem to really care about me and understand me, I might open up a bit more, but you know, I don't want to end up in hospital again. Sometimes they can over-react and take things the wrong way and the next thing I am being admitted, so I have learned to work out who I can trust and even then I would usually rather talk to my family.

For Chris, a lack of trust meant that he would not risk discussing feelings and emotions with a social worker.

I just get social workers to help me with filling out forms and making appointments and things. I don't talk to them about anything personal. I have been burnt in the past by social workers when I was younger and so I keep those things to myself now.

### *Genuineness and honesty of social workers*

Participants closely related the concept of trust to genuineness and honesty. 'Being real' helped to build trust with social workers. Clients emphasised that genuineness and honesty were integral to a caring interaction. They appreciated social workers who were 'up-front'. Archibald mentioned the importance of 'being real'. He said:

I like it when they are real. She might say, 'I can't be bothered doing that', and she might say, 'Oh, don't be lazy' or something. I like that.

One third of client participants said that it was obvious when a social worker only pretended to care, that is, when the care was not genuine. Jessie displayed disgust as she spoke about how a social worker pretending to care had made her feel in the past:

It is really important that they are genuine, because people can really tell. Even if they have to tell you that they are feeling frustrated it is much better than them pretending. There was a social worker whose body language showed they were really annoyed with me and when I asked them if they were annoyed they stopped doing it and said, 'No, I am happy you are telling me this'. I was thinking, 'I know you are annoyed'. So I just felt really silly and thought, 'Just say it'. Pretending to care is worse than not caring at all.

Eve also expressed that pretence could easily be identified. She said:

You can smell it if it's not real. You can look into a person's eyes and know that they don't really care, that they are just doing a job.

And Margaret realised that constant care is not always realistic. She was adamant that it was important for social workers to be up-front when care was not possible.

She explained:

Sometimes they will have their mind on something else, and I understand that. It's up to the person to say I'm not available right now and not just pretend to care and listen.

Emma's long term experience with social workers assisted her to recognise the difference between genuine and disingenuous care. She had learned to guard herself against the latter. She explained:

If someone just says what they think they are meant to say I pick up on that fairly quickly and that could be because I've had a lot of counselling and I've had good and bad experiences. So, I'm probably a little bit more watchful because I know it can be bad. If I recognise the pretence then I will water my story down and don't go back to that person again.

### *Social workers maintaining confidentiality*

Three participants stressed the importance of confidentiality, believing attention to this principle is crucial to caring practice. Emma mentioned confidentiality many times throughout her interview. These are a few of her comments:

It is paramount to me that my information stays private, that they have really helped me to feel – and I know at the end of the day I have no control over it – but if they've been really professional in a gentle, kind way and they've talked to me about it being confidential, they've talked to be about what happens with notes, they've talked about where the information goes and how long it stays there and all of that – it makes me feel better.

One social worker I saw didn't even talk about confidentiality. I said, 'Do you need my files or anything?', and she said, 'Oh no, but I can get them'. I just said no, I didn't want that because I knew I didn't want to tell her much. She didn't even mention confidentiality and that is so important to me.



She took copious notes, but she didn't talk about who would see them or what would happen to them. That's uncaring to me, because would she like someone to do that to her? I was in too much of a state to think about it at the time, but later I thought, 'She took notes, what's going on with those?'

Eve presented a traumatic experience regarding confidentiality. She had been seeing a social worker for several weeks, discussing her struggle with post-traumatic stress disorder. She felt that her privacy had been breached, and was stunned by the complete lack of care. She shared her story as follows:

When I saw him he said, 'Well, I've had a round-table conference with all my colleagues about you'. I'm like, 'What!' He said, 'We had a lovely chat about you'. I've just envisaging everyone sitting with their feet on the desk drinking beer. He said, 'Oh, we've come up with what it is with you – you have Cinderella complex', and I said, 'I don't know what you're talking about', and he said 'It means you think you're hard done by'. I just picked up my bag and said, 'Thanks very much, see you later'. I can laugh about it now, but bloody hell, can you believe it? That just showed me how much he understood and cared.

Emily explained that confidentiality was something she was always wary of:

My social worker doesn't write any notes, which is good. I get nervous when they start writing down what I am saying. In the past a social worker used to write things down but then let me look at what she had written and ask if I was happy with it.

Scott appreciated the fact that his social worker would never talk about him to staff at the residential facility he lived in, without him being present. He commented:

Before he goes he might talk to the staff, but he won't talk behind my back. I am there too.

## **Experiencing Care by Social Workers as Paying Attention to Needs**

Client participants spoke about the importance of social workers paying attention to their needs as an indicator of caring practice. The sub-themes that I identified from this main theme were social workers recognising needs (n=6), the little things that social workers do (n=6), social workers providing options and guidance (n=6), social workers addressing practical concerns (n=5), and social workers following up (n=3). Two participants recognised that social workers sometimes find it difficult to meet

the needs of their clients – not due to a lack of care, but because of external constraints.

## **Social workers recognising needs**

Focussing on the needs of the client, without making assumptions about what those needs might be, was considered an important aspect of care for 11 of the 15 participants in this study. Eve summed this up when she stated:

For me it's as simple as saying to a person, 'What do you need?', and that might be something as simple as going for a walk together. You won't know what someone needs unless you ask and then listen. It is amazing how many social workers don't do that. They just make up their own minds about what you need.

Alex concurred with this view when she said:

To care is to be sympathetic to people's needs – individual needs – and understand why people are the way they are. You need to ask questions though and not be judgmental about the answers, because then that just shuts people down.

Margaret described how her social worker was committed to meeting her needs:

She would ask a few questions and really listen to my response. She would wait until I finished talking before asking the next one. She would find out the main thread and what was the next thing she needed to ask. She had the ability to see the bigger picture of it all and we could then work out together where to go from there. It was brilliant!

Pink explained how her social worker considered the needs of the clients when organising a group:

The group was going to be on Wednesdays, but because I had something else on, she changed it to Tuesdays. She worked with me and everyone else to make sure that we could all attend. That felt like caring.

Luke described a negative experience he had with a social worker who he felt did not seem to understand his situation or his needs. Luke was seeing the social worker due to his struggle with alcohol and drug addiction. He walked away feeling that the experience had done more harm than good. He said:

He was very bossy and saying, 'You should be doing this and you should be doing that. I'm here to help you and if you don't do what I say, you are wasting my time'. I just thought, 'Well, don't worry about it'. He was just so rude – no understanding, no talking about it first. He just told me I was stupid for drinking and taking drugs. He didn't even ask any questions about where I had

come from and why I might have turned to drugs and drink. That is definitely not what I needed. It just made me feel worthless and go home and drink more.

## **The little things that social workers do**

In common with the social workers who were interviewed for this study, client participants spoke about how often it is the small, extra things that social workers do that indicates care. Emily appreciated an extra visit from her social worker when she was unwell. She commented:

I was really ill and she came to my unit and she showed that she cared by staying and talking to me...She made that extra visit outside working hours, so that was nice of her. She could have waited until the following day, but she didn't. She came straight away.

Pink shared how valuable she believed a small act of care to be, highlighting the fact that it doesn't need to take up much time. Her social worker was going on holiday for a few weeks and was aware that Pink felt somewhat vulnerable knowing that she would not be available. The social worker took a moment to provide Pink with some reassurance. This occurred at the end of a group session. Pink explained:

She just came up to me and gave me a really big hug. She whispered, 'Take care, and as soon as I get back we will be in touch'. Just doing that gave me a feeling that I would be alright while she was away and she told me if I have any problems to ring the service. So, it was just that nice little thought before she left... It's that little bit extra that makes a difference – it helps me persevere with my own struggle.

Receiving cards and compliments from social workers also helped clients feel that they mattered to their social workers. Jessie shared the following thoughts on the little things that demonstrated care:

It's just kind of little things that make me feel cared for, like making a joke or, you know, saying, 'Your hair looks nice'. Yeah, it's just the random things that are not part of the job that make you feel like you matter. Yeah!

Alex was touched when her social worker gave her a birthday present. She explained:

She actually gave me a birthday present and she is the only person who did. It was donated to the agency, so she didn't have to pay for it, but that doesn't matter. It was a bed cover and it is beautiful – I love it. She knew that just saying happy birthday made a difference because my family don't care. It meant a lot.

Bob and Jessie both spoke about how they experienced care when their social workers acknowledged them outside of the professional context. They said:

I saw him in the library and he came over and said hello and asked how I was going. He didn't have to but he did. That made me feel he cared about me (Bob).

I saw her down the street and she smiled and waved and we just kept walking, and I thought, 'Oh she does really like me' (Jessie).

Jessie believed it was important to discuss protocols around meeting in the street or in other environments. She commented:

I think it's really important. I think the first time you meet with a social worker you have to talk about that. I can understand if someone wants to have boundaries about that sort of thing – that's fine, but I think they just have to explain it to you first so they don't snob you and then you misunderstand it. Like, I don't so much anymore but I used to be sensitive about all these things and think they didn't like me if they didn't speak to me in the street.

## **Social workers providing options and guidance**

One third of participants valued being given options over being told what to do.

Comments included:

I like that brain storming stuff – you know, where you come up with a range of options and talk about each one to work out what I think I want and need (Margaret).

It's good when they try to find solutions, without actually telling you what to do. I don't go to a social worker to be treated like a child. Some act like you are stupid and have no idea what is good for you (David).

Friendly advice, but not throwing it down your throat – actually sitting down and listening and then saying, 'How about this or that?' (Luke)

Three participants believed that in times of crisis it is sometimes necessary for social workers to take control and make decisions for the client. Alex explained that during a crisis often people cannot think clearly and need to be able to rely on their social worker to make decisions for a while. She explained that it is important that such decisions are made with great care and consideration. She commented:

When you are too 'out of it' to establish what you want or know what's best for you it's nice to be able to rely on someone you know isn't going to lead you down a bad path. If you aren't capable of looking after yourself it can be really bad to get burnt by someone who is supposed to have helped you, because I've seen it so many times.

Bob had experienced times when he valued having a social worker tell him what to do. He said:

Sometimes I can't think clearly for myself and like being told what to do and even pushed a bit.

Jessie echoed these views when she explained:

Sometimes when you are in a really big crisis and you don't know up from down it does help to have someone that's confident that says, 'you need to do this and you need to do that' and you just follow their advice. It is not uncaring during those times to be a bit bossier. Even if it's wrong it kind of doesn't matter. You just need something. You just have to do something and if it's a mistake it doesn't really matter because at least you have got out of the panic.

## **Social workers addressing practical needs**

For some participants, meeting needs was largely about providing practical support.

Chris's only requirement of a social worker was to meet practical needs. He therefore, viewed a caring social worker as one who respected and recognised this.

He said:

All I need from my social worker is to keep me on track with my medication and everything, go to the doctor with me and make appointments for me. My social worker is good like that and doesn't expect me to have deep and meaningful conversations...He has learned that is not who I am.

Scott valued his social worker discussing his medication requirements. He commented:

He notices if I go a bit funny when my medication drops and will ask me about it. That's good, because it shows he cares enough to really take notice of these sorts of things. He is not a doctor and doesn't prescribe the medication, but he knows me well and can tell when it might be time to talk to my doctor.

Eve believed practical care to be as important as what she described as 'the more compassionate side of care'. She explained:

For me it's also very much about being practical. Care has to be holistic, where it's about doing something about the problem as well as being compassionate and understanding.

And Emma spoke about the value of practical support when she was anxiously awaiting a hospital visit:

She made sure I had someone to take me in and that I could let them know to call her if necessary as well. So my friend could get hold of the social worker if needed without me having to find her number if I was feeling really bad. They

were little ideas and she would say ‘Would that work and would that work’. It was really good. It was like we were coming up with this little plan together. And she was really practical.

Pink believed that practical care complemented emotional care. She explained:

You know, social workers have to have the lot – they have to be able to understand what someone is going through and be able to talk and listen, but they also have to be able to do that practical stuff.

## **Social workers following up**

Three participants spoke about the idea of the social worker ‘following up’ with the client. While this is not something that Emma had experienced, she believed that a follow-up phone call would be a caring and appropriate thing to do. She said:

I tell you one thing that I would love, but that has never happened is a follow up call. So, when you have your last session or even a one-off thing, that they say, ‘Would you like me to call you and see how you are going in a couple of weeks?’ If they were to call and say something like, ‘I’ve just been thinking about you and wondering how you are going’, I would feel really cared for and really valued. Then if you had anything niggling from the last session – anything you weren’t really comfortable about – you would have the opportunity to ask questions. Yeah, that would be good.

While Alex had been promised a follow-up call from a social worker she had seen in a crisis situation, the call never eventuated. This left Alex feeling as if she did not really matter. She explained:

She told me she had my contact details and she would check on me in the next couple of weeks and would progress with the care and help me out, and I’m still waiting for the call five months later. So, if you promise to help out or you promise to give someone a courtesy call and then you don’t, then that’s not a good thing. It kind of makes you feel unimportant, that you are only helping in the first place because you have to. It kind of dents the armour in you.

And Bob said:

I really like it when they call you and check on you if you haven’t seen them for a while. That makes me feel that they care and my wellbeing is important to them.

Receiving a follow-up phone call was appreciated and considered a caring act, however, it did not seem to be a common experience for the participants of this study.

## Constraints on social workers doing care

Only two client participants spoke about noticing the constraints that social workers face, that is, difficulties that can impede their ability to meet needs in a caring way.

Emma said she realised that often in organisations driven by the medical profession, it can be difficult to gain access to a social worker. She explained:

I was at the hospital with my sick daughter. She was in such a bad state and I just needed someone to help me because I was in shock. I didn't have a lot of faith in being able to get through the system to get the social worker. It did take some persuading, which was hard because I was not up for a fight, but eventually I was able to see someone. The social worker was annoyed that she hadn't been called earlier.

Pink highlighted the difficulties she saw social workers face. Her comments included:

I see that it's hard because they are under such time and other constraints. There is probably enough work where I go for another couple of social workers, but it's just not allocated. You know they try not to show they are stressed, but we are not silly, we know.

You just see it, where they are always so busy and you can see the strain in their faces and the frustration, even with my social worker who is wonderful, the frustrations of not being able to do what she wants to do and then they can't give the quality of care they want to each client. I can see that.

In spite of this, Pink believed that her social worker continued to care as much as possible. She said:

She is great! If she is snowed under she will call me and explain and let me know she may be held up for a while. She is really good like that, really thoughtful on letting me know if it's a problem. Here the other week we couldn't do the group and she rang everybody in the class and let us all know one by one that there had been a problem to do with work and she'd have to call it off that week and we would catch up the following week. A lot of people would just get their receptionist or someone to do that, or send a text, but she didn't. That is all it takes to know she cares. I understand the pressure she is under.

## Reflecting on the Importance of Care in Social Work Practice

Twelve of the 15 participants specifically highlighted the importance of care in practice. Jessie believed care to be more important than knowledge and skills. She stated:

The thing is, it is really someone's attitude that makes the whole difference, the way they treat you. If they stuff up their technique and they say the wrong thing – those little mistakes you can forgive. Even if they make big mistakes you can forgive them, but it's really definitely their attitude towards you that matters. If they get everything completely right but you know they don't really care that much, then the rest doesn't count... You know it's something that people don't really talk about – that's why I was so glad you are doing this research.

Jessie wanted to convey an important message through her interview:

I just want to tell everyone it really, really matters! If you don't care about people it really isn't the right career to head into. If it's just about having a good technique or being a 'good' social worker then find something else to do.

Pink shared Jessie's view that a caring attitude should be a pre-requisite for a social worker. She commented:

If a social worker can't care, they shouldn't be a social worker. Who knows, they could be in your shoes tomorrow and they need to think about that.

Eve described care as vital to good practice. She said:

It is the most important thing to me, that's the most valuable and the thing that has helped me the most.

Scott said:

If my social worker didn't show care then I wouldn't want to see him. I certainly wouldn't talk about anything personal.

Alex believed that caring practice could make the difference between life and death.

She explained:

If you are feeling suicidal, then it is very, very important – you know somebody could die. People think, 'Oh it's nice if they care', but it's more than nice, it sometimes can be really important.

Red Devil commented:



To be caring and take stuff in and then deal with the situation in the right way is far more important than anything else. Not to be caring can scar people for life.

Emma believed that most people who visit a social worker are in a vulnerable position. As a result she considered it obvious that a caring demeanour and response are crucial to providing a positive experience and this starts with the very first contact. She explained how she would often assess the level of care with a phone call prior to her appointment:

When you visit a social worker you are usually in a position of needing care... If I get a hint of them being abrupt or any sort of anger in their voice I have been known to cancel an appointment. This can actually stop me right there and then, because I am the vulnerable one and I need to feel comfortable.

Bob had noticed a difference between social workers and other professionals in terms of care. He said:

Social workers do seem to care more than doctors and psychologists. I guess it's because they are trained to care more. It's probably why I usually like them more.

While three participants (Chris, David, and Nicky) did not explicitly speak about the importance of care, it was evident in their comments throughout the interview that they did to some extent value caring social work practice. They appreciated feeling valued by their social workers, as indicated by comments such as, 'My social worker spent some time looking at my art-work and told me I was really good', and 'He always turns up when he says he will or lets me know when he will be late', and 'She understands me and knows that I don't want to talk about emotional stuff'.

## **Concluding Comments to the Chapter**

In this chapter I presented how social work clients experienced and interpreted care in their interactions with social workers. All participants placed value on caring practice. Care not only helped clients to feel valued but also served to increase confidence in their own strengths and abilities. Some believed that their social worker was the only person in their life who really cared about them. When they were conscious of care their overall experience was much more likely to be a positive one. In contrast when they did not experience care they felt de-valued,

somewhat powerless regarding their situation and at times, frustrated and angry. Some experiences of uncaring practice were recognised as damaging. Participants were resistant to what they perceived as uncaring practice. Such resistance was identified by them as a refusal to open-up emotionally, walking out on the social worker and/or not returning to see that particular social worker. While Chapters 5 and 6 reveal very little about ‘uncaring’ practice, this chapter provides strong evidence that care, as experienced by the clients in this study, is sometimes lacking in social work practice. This concludes the presentation of results in this thesis. The following chapter discusses how these findings inform an ethic of care for direct social work practice.

# Chapter 8: Discussion

We are not ‘justified’ – we are obligated – to do what is required to maintain and enhance caring. We must ‘justify’ not-caring; that is, we must explain why, in the interest of caring for ourselves as ethical selves or in the interest of others for whom we care, we may behave as ones not caring toward this particular other (Noddings 1995, p. 22).

## Introduction to the Chapter

The previous three chapters presented the findings of this study, focusing on participants’ views of how care operates in direct social work practice. In this chapter I discuss these findings in answer to the research question: *How does thinking about, doing and experiencing care in direct social work practice inform an ethic of care for the profession?* To date there has been considerable debate about the value of an ethic of care in social work practice. Many authors suggest that these debates are particularly relevant to the challenging contemporary context that is driven by neoliberal ideologies and increasingly bureaucratised organisational policies and procedures. My study aimed to offer a unique contribution to existing theories and discussion by moving beyond abstract ideas about care, thus illuminating how an ethic of care is enacted in everyday direct social work practice. While many of the ideas identified in the literature are supported by the findings of this thesis, participants have shared some alternative views and practice examples that reflect new ways of thinking about how an ethic of care relates to the professional social work context.

I begin to answer the research question by dividing the chapter into three parts: ‘thinking about care’, ‘social workers doing care in direct social work practice’ and ‘clients experiencing care in direct social work practice’. The section on thinking about care discusses how social workers and clients conceptualised care in direct social work practice. While the two cohorts mostly agreed on what it means to care and what constitutes caring practice, the main difference lay in the emphasis clients placed on trust as a core component of the caring relationship.

The main findings relating to how the social workers who participated in this research ‘do care’ pointed to the complexities involved in maintaining care in the professional context; a context driven by neo-liberalism, evidence based practice and New Public Management; and a context that imposes constraints on caring social work practice. I discuss how the social workers continued to care in spite of the constraints of these contexts, demonstrating ‘moral courage’ and their commitment to taking on care as an ethical responsibility. I emphasise the intersection between social workers doing care and attending to issues of social justice, and I highlight the emphasis that social work participants’ placed on self-care as a necessary component of caring direct social work practice.

I progress the chapter by discussing the main findings from the clients’ experiences of caring and/or uncaring direct social work practice and how they inform an ethic of care for direct social work practice. I show that the presence or absence of a caring approach was fundamental to client participants’ feelings of satisfaction with the overall experience of working with a social worker, and perceptions of how helpful the intervention proved to be. I discuss the three core findings from the client participants’ data: the ‘experiences of caring social work practice’, in which ideas about what constitutes care, mainly support those of the social workers in this study; ‘trust’, which refers to the importance clients placed on trusting their social worker as a crucial aspect of caring social work practices; and experiences of uncaring practice. The number of stories of uncaring practice and the obvious impact of these negative experiences on clients indicated that this alarming finding was an important topic for discussion. I end this chapter by discussing the central finding that was evident across all of the research data, that is, that caring social work practice is ultimately about valuing the client as a significant other.

## **Thinking about Care in the Professional Context of Direct Social Work Practice**

Many aspects of care that were mentioned by the social workers in Chapter 4 of this thesis, such as listening, attending to needs, non-judgment and self-determination,

are commonly linked to familiar social work principles outlined in the AASW Code of Ethics (2010) and the AASW Practice Standards (2013). These documents also briefly mention empathy and compassion, yet no explanation of what the terms mean or how they are enacted in practice is provided. Empathy, compassion, love, 'being there' and valuing/honouring the other underpinned social workers' beliefs about care and accounts of caring practice and according to social workers were the features of care that differentiated social workers merely 'doing their job' and doing their job with care. It was these subtle aspects that reflected Tronto's (1993, p. 105) phase of 'caring about', adding a deeper sense of what constitutes genuine caring practice. This supports Bevis' (1988, p. 51) view that genuine care does not just arise from duty and that it requires an emotional response. I progress this section by discussing social worker views of care as being about love and compassion.

### **Thinking about care as compassion and love**

The term 'compassion' was used more than any other word to describe care by both the social workers and clients who participated in this research. Even when considering the importance of recognising boundaries and limits to care, social workers RM and Lesley argued that clients must be attended to with compassion. While ethic of care theorists (Held 2006; Tronto 1993; Noddings 1984), nursing scholars (Engelbreton 2004; Morrison 1991) and social work scholars (Gray 2010; Hugman 2005; Meagher & Parton 2004) do mention compassion, it is a concept that is rarely spoken about in-depth when discussing care. The participants of this study also did not discuss the concept of compassion in depth. Like 'care', the meaning of compassion seemed to be taken for granted. It was, nevertheless an important component of care to the participants of this research and the meaning they attributed to it may best be described by Morley and Ife's (2002) general idea of a 'love of humanity'. Social workers, Cloudy Bay, Kate and Shirley explicitly mentioned the influence that Morley and Ife's (2002) article had on their own thinking and practice. For them it provided confirmation and gave credibility to their existing beliefs that feeling and demonstrating a sense of love (in its platonic form) towards clients is an important and valuable part of caring practice. Until they had read the Morley and Ife (2002) article, they hesitated to use the word 'love' which they believe is often perceived to be inappropriate and unprofessional in the professional world of social

work practice. According to Morley and Ife (2002, p. 75) to love is to feel and connect with a common sense of humanity and the struggles that each of us inevitably face: it is this idea that appears to capture the views of the social workers' about how compassion links to care. Social workers supported the contentions of ethic of care theorists' (Held 2006; Gilligan 2002; Tronto 1993) that approaching care with compassion and love is compatible with promoting self-determination and autonomy.

### **Thinking about the relationship between care and autonomy**

Even though the social workers who participated in this research were aware of the importance of promoting self-determination in their practice they challenged views that care creates co-dependency and strips people of their autonomy (Allmark 1995; Curzer 1993; Nelson 1992). For them it was about determining the right form of care in each specific situation. On the whole, social workers strongly expressed views that care must be taken not to interfere with their client's autonomy and self-determination when caring for them, unless absolutely necessary or unless it was what the client wanted. Caring practice meant working 'with' the client whenever possible, and working towards meeting the client's needs as expressed by the client, instead of imposing the social worker's own views and solutions on to the client. Social workers in this study believed that 'working with' rather than 'doing to' marked the difference between genuine care that occurred in relationship with the client compared to maternalistic/paternalistic forms of care that demonstrate totalising power over the client. Maternalistic/paternalistic care was described by social workers as diminishing, controlling, smothering, and as a form of rescuing. Having said this, social workers did recognise that the specific context and the level of autonomy a client had in a given situation needed to be taken into account. Amber articulated this view well when she described the social worker as a temporary bridge, that is, a means of getting to the other side of the problem, and a bridge that could and should be removed once the client regains control of the issue and their own self-determination.

Contrary to the narrative that underscores the critiques of ethic of care theory in the literature (Allmark 1995; Curzer 1993; Nelson 1992), clients did describe times

when they appreciated and needed to have decisions made for them and when they felt they needed 'looking after'. Such times tended to be when clients were experiencing an emotional crisis and as a result they were not able to think clearly, or they were physically unwell and relied on their social worker to advocate on their behalf. The clients indicated that if social workers left them to their own devices, when at their most vulnerable, then this would have been extremely uncaring. These findings indicate the complexity of the caring relationship, as the level of 'interference' in clients' lives shifts and requires flexibility. Sometimes the caring thing to do was for social workers to use their professional power to make and enforce decisions for the client – to enact a 'duty of care'. Mostly the caring thing to do was to trust in the ability and knowledge of the client to know what is best for them. Sometimes the caring thing to do was somewhere in between 'taking over' and encouraging the client to have complete autonomy over their own life. These findings support Clements' (1996, p. 24) contention that autonomy is developed through relationship, and ethic of care theorists' (Noddings 1995; Tronto 1993) views that care can increase autonomy and re-instate a certain level of independence, especially for the most marginalised individuals and groups in society.

### **Thinking about the relationship between care and justice**

The social workers who participated in this research argued that an ethic of care for direct social work practice must incorporate an ethic of justice. Narratives of care were often intertwined with considerations of justice, supporting the view that care and justice are logically compatible and cannot be separated in the real world of ethical decision making (Held 2006, 1992; Gilligan 2002; Heckman 1999; Jagger 1995; Tronto 1993). These findings are consistent with Kuhse's (1995, p. 216) view that principles are necessary in order to create ethical discourse and provide justification, that without them there are only 'particularities and unguided feelings'. Participants often spoke about care as a response to injustice, inequality and unfairness. They referred to care as something that is sometimes necessary to reinstate autonomy and independence, and these are terms that are associated with an ethic of justice.

The language used by participants reflected the intersection between care and justice. The word 'respect' was frequently used to describe care, indicating that while respect is a principle of deontological ethics - it was also viewed as a form of care. This idea of respect particularly aligns with participants' views that professional care should not be paternalistic/maternalistic, but instead it should be enacted in relationship with the client in a way that shows respect for their knowledge and understanding of their circumstances. In much of the literature on ethic of care theory (Held 2006; Tronto 1993; Gilligan 1982) care and respect are viewed as separate but complimentary concepts, with respect being aligned with an ethic of justice. The findings of this research fit most closely with Dillon's (1992, pp. 116-119) idea of 'care respect', which he describes as:

Care respect thus involves viewing persons simultaneously in the abstract and in the particular, valuing this person as the fully specific concrete individual 'me' she is because she is a particular individual and human 'me.' Care respect, we might say, sees at the same time both the person in the individual and the individual in the person (Dillon 1992, p. 118).

It is this idea of respect as being about valuing another person simply because they matter as a feeling, thinking human being that differentiates it from general notions of respect that suggest that a person must 'earn' the right to be valued (Dillon 1992, p. 113). 'Care respect' also differs from the variety of respect that applies as a universal principle, with everybody being treated the same, without consideration of their unique character and circumstances (Dillon 1992, p. 115). Instead, 'care respect' embraces the individual person and the differences that exist between people involved in caring relationships (Dillon 1992, p. 116). Similar to the findings of this research Dillon (1992, p. 115) argues that, 'What matters about each of us is not (only) some abstract capacity but the fact that we are the specific concrete individuals that we are'.

As Dillon (1992) contends, 'care respect' helps build trust. While mostly clients shared common views with social workers about the features of caring practice, one of the main differences between the social workers' and the clients' views of care relates to the significance clients placed on trust. Only a couple of social workers mentioned trust in passing, whereas 11 of the 15 clients who participated in this research spoke specifically about what they perceived to be an important link



between care and trust. Trust will be discussed in more detail in the section of this chapter titled, 'Clients experiences of care in direct social work practice'. In the next section I answer the research question by discussing how the social workers 'did' care in direct social work practice, and how this informs an ethic of care for direct social work practice.

## **Social Workers Doing Care in Direct Social Work Practice**

Social workers cared for their clients in numerous ways: they built relationships with their clients; they advocated for them when social justice issues arose; they drew on professional skills and knowledge in an attempt to meet their needs; and they listened with empathy and compassion, and without judgment. They did care by conducting risk assessment with care, enacting a caring presence, and challenging the professional context and the constraints imposed by organisational policy and the underlying political context. At times doing care required enacting a 'duty of care' which involved protecting the client and others who may be at risk of harm. I end the section by discussing how social worker participants did care by attending to self-care.

### **Doing care by building relationships**

Building relationships by spending time with clients, getting to know them and ensuring the client felt comfortable was considered key to being able to care for clients in a way that resulted in the clients' needs being met. This supports arguments by social work scholars that promote relationship-building as a way of countering some of the deleterious effects of managerialism (Trevithick 2014; O'Leary, Tsui & Ruch 2012). The findings also support the view held by ethic of care theorists (Tronto 2013, 1993; Held 2006; Sevenhuijsen 2003; Gilligan 2002, 1982; Noddings 1984) that it is the attention to relationships that denotes the fundamental difference between an ethic of care and an ethic of justice. Ethic of care theorists argue that care can only occur through relationship as it is through relationship that problems are contextualised and understood as being a part of a

bigger picture. My study demonstrates that building relationships with clients reduced social workers' tendencies to make assumptions and allowed the social workers to see beyond the presenting problem to identify strengths and resources held by the client. As Saleebey (2009, pp. 15-16) notes:

Clients have hopes, have interests and can do things masterfully. These may be obscured by the stress of the moment, submerged under the weight of crisis, oppression, or illness, but nevertheless, they abide.

An original finding of this research was that the social workers who participated in this research argued that like any caring relationship, the care that occurs between social workers and their clients is not always about being gentle and being 'nice'. This was particularly evident in the data provided by Billy, Lesley and RM. They spoke about times when the caring thing for them to do was to be brutally honest about impacts and consequences of clients' actions. There were also times when social workers in this study needed to make hard decisions and take measures that protected both their client and/or third parties who could be harmed or exposed to significant negative consequences as a result of circumstances and behaviour. This was not seen to be about being paternalistic or maternalistic, but instead helping clients face the reality of their situation. Therefore, there were occasions when it was considered necessary to interfere with the self-determination of the client. It is important to note that such interference was not deemed to be uncaring and the social workers continued to work 'with' their clients as much as possible. Ultimately, social workers concurred that attempting to avoid serious harmful outcomes was the most caring thing to do in the long-term, even if a client's self-determination was not always retained in the process. These findings reflect the particular role of social workers to not only protect and care for their client, but to also consider the impact of certain circumstances and/or behaviours on others and society as a whole. Therefore care extended beyond a focus on the individual client social workers were working with, including working in the context of direct practice context. It is evident from the findings of this research that the social workers continually needed to reconcile social work values that pertained to care and the inevitable requirement to attend to risk factors that they were presented with.

## Doing risk assessments with care

There were two common features present in all of the different cases that social workers spoke about when considering risk and harm to third parties. First, in spite of sometimes having to deny a client's rights to self-determination, they did not stop 'caring about' the client and continued to demonstrate this to the client. Second, they continued to work in relationship with the client as decisions were made and necessary processes were followed. The findings show mixed views about the impact of a strong focus on risk management on care. While some social workers expressed concerns that the current professional context of social work practice places too much emphasis on 'risk' at the expense of caring practice, others viewed attendance to risk factors as an important part of caring practice. In Stanford's (2008, pp. 217-218) study on social workers' responses to risk, she identified risk as a pervasive, conservative moral force, yet a force that social workers mostly resisted. Resistance did not occur through ignoring risk but by enacting a moral stance of compassion and care. McAuliffe and Chenoweth (2008) acknowledge both sides of the debate around risk. On the one hand they argue that an all-encompassing focus on risk can 'reduce everything to safer extremes of black and white' and true responses to human need can 'become stifled and bound up in rules and regulations' (2008, p. 39). On the other hand McAuliffe and Chenoweth (2008, p.39) highlight the dangers of ignoring risk in the name of care, stating:

They [social workers] may fall into the equally insidious trap of seeing all tools associated with risk management as oppositional to the core purpose of care for others...The discerning practitioner, it is argued, will acknowledge risk (for vulnerable service users, for self as practitioner), for it is virtually impossible and potentially could be negligent not to do so, but will selectively search for those foundational principles that underlie good practice and provide sound frameworks for consistent decision making that will hold up under scrutiny.

Therefore, according to McAuliffe and Chenoweth (2008), risk assessment has its place in social work practice and is not necessarily antithetical to caring practice. Their argument supports the views of social workers, RM and Lesley, who considered risk management to be an integral part of enacting care in their practice. The findings of this research support the view that an ethic of care for direct social work practice cannot avoid paying attention to risk and nor should it, however risk assessment needs to be conducted with 'care' rather than simply following formal, standardised processes and ignoring individual contexts (McAuliffe & Chenoweth

2009; Stanford 2008). Along with the acknowledgment that a part of the caring role in direct social work practice involves attending to the risk factors, and ensuring that clients and others are safe, there was also an acknowledgement that a 'caring presence' was an important part of their practice as discussed in the next section.

## **Doing care with a caring presence**

An aspect of doing care that resonated strongly throughout these findings was enacting a caring presence. Caring presence is a common theme in the nursing literature (Covington 2005; Engebretson 2004; Snyder, Brandt & Tseng 2000; Eriksson 1992; Watson 1985; Leininger 1981), but not evident in the social work literature. The social workers in this study shared many examples of practice where the only or most appropriate form of intervention was to simply be there for their client. They conveyed care by listening, holding their hand, and giving them space to process their suffering, and generally providing emotional support. These findings share similarities with Engebretson's (2004) nursing case-study in which a student nurse was able to develop a strong connection with a grieving mother just by sitting with her in silence and offering unconditional support.

There were many times when the social workers in my study had no answers or practical solutions to a problem or situation, and times when clients were in great distress or not in a fit mental state to talk about their issues. These situations called for something other than the application of evidence based practice techniques, therapeutic practice models, or the universal rules and principles of ethical codes. According to the social workers I spoke with clients required something more basic and 'pure': the presence of another human being who genuinely cared about the client as a person. They required someone who was prepared to sit with the discomfort of witnessing suffering and realise the value and power of subtle acts of care in its rawest form. As Engebretson (2004, p. 245) claims, it is when a common humanity is recognised and acknowledged that authentic care occurs; all too often this does not happen, because professionals tend to 'hide in their professional role'. While it may be difficult to measure the effectiveness of caring presence in terms of outcomes, both Kate and Yasmine were convinced that such presence is meaningful, partly due to feedback they had received and partly due to the fact that it felt like the

right and only appropriate thing to do at the time. Others believed that the motivation for this form of care was born out of a sense of compassion for the client as a result of an intuitive knowing that it was the right thing to do, rather than a means to an end.

Tronto's (1993) key phases of caring were reflected in the accounts of caring presence. Social workers both 'cared about' and 'took care of' their clients. Tronto (1993) refers to 'caring about' and 'taking care of' as two distinct concepts that link to one another with an orientation towards care providing the motivation for caring action. I identified a subtle difference in this research with these two concepts often overlapping. Action was sometimes passive yet powerful, as in the case of 'just being there', when 'caring about' was described as an intervention in its own right. Next, I discuss a different aspect of 'doing care', demonstrating how social workers enacted care by challenging the professional context that direct social work practice is situated in, and how this informed their ethic of care for practice.

### **Doing care by challenging the professional context**

Concerns expressed by some social work academics (Smith 2011; McDonald 2006; Webb 2006; Evetts 2003; Lymbery 2001) that New Public Management and the neo-liberal political context poses significant problems for caring social work practice are reinforced by the findings of this study. In spite of social workers having a clear idea of what constitutes caring practice, they revealed that care is not always easy to maintain when faced with policies and procedures that conflict with social work values, time and economic constraints, time-consuming administrative procedures and a hyper vigilant risk averse agenda. None of this stopped social workers from 'caring about' their clients, however there were times when it was difficult or impossible to demonstrate care to the degree that social workers would have liked.

In common with previous research (Gregory 2010; McDonald & Chenoweth 2009; White 2009; Stanford 2008; Meagher & Healy 2003; Vonk 1999), my findings showed that social workers identified ways to continue to care and to challenge the constraints they faced in their practice. Participants in this research made use of gaps in systems that provided room to care, thereby demonstrating creativity in their

commitment to care for others. Others blatantly ignored rules and took professional risks while providing moral justification for their actions. Some social workers stood up to managers and other professionals by advocating strongly for their clients and challenging practices and policies that were antithetical to caring practice. Others used more strategic methods by building relationships with managers and colleagues and choosing to only fight the battles that were considered to be most important. In order to do this, I argue the results indicate that social workers used moral courage and took responsibility for their commitment to caring practice, which I now discuss.

### *Moral courage*

Peterson and Seligman (2004, p. 197) define moral courage as ‘exercising courage in any situation in which there might be opposition to what you are doing in a way that might result in personal cost to you if you went ahead and did it’. Often the demonstrations of resistance enacted by the social workers in this study revealed significant levels of moral courage, with social workers facing feelings of insecurity and uncertainty in regards to repercussions and consequences of the decisions they made and actions that they took. This was particularly highlighted in Mary’s account of assisting a child to write a letter to the court about parental abuse. While Mary strongly believed in and felt justified in her professional decision, even after complaints were made against her by the child’s father, the uncertainty around the consequences of this action engendered a sense of fear that her job may have been in jeopardy.

Moral courage is viewed by van Hooft (2006, p. 127) as a moral virtue that is motivated by love or care for others, and which overrides the fear that necessarily precedes an act of courage. The commitment to protect and/or defend someone or something that one cares about takes precedence over the feared consequences (van Hooft 2006, p. 138). MacIntyre (1981, p. 32) also views courage as a virtue, arguing that:

If someone says that he cares for some individual, community or cause, but is unwilling to risk harm or danger on his, her or its own behalf, he puts into question the genuineness of his care and concern. Courage, the capacity to risk harm or danger to oneself, has its role in human life because of this connection to care and concern.

Van Hooft (2006, p. 141) asserts that courage builds confidence, because when courage leads to a moral good it becomes easier to be courageous in the future. This premise was evident in the findings of this study as social workers with many years of experience (Cloudy Bay, Sally, Shirley and Yasmine) expressed more confidence in rebelling against the system or strategically navigating through it than those who had worked in the field for only a few years (Billy, Kate and Mary). Courage can be seen to have developed as a result of social workers taking responsibility to ensure care is extended towards their clients.

### *Taking responsibility for care as an ethic in practice*

A sense of responsibility to meet the needs of clients often overrode social worker participants' sense of duty to organisational rules and regulations. These findings support Tronto's (1993) view that responsibility is a key dimension of an ethic of care, in which care is recognised as a moral necessity because it is the 'right' thing to do. The responsibility that social workers take on to continue to care for their clients may conflict with organisational policy. This was evident when Cloudy Bay decided to buy cigarettes for a client who did not have the freedom to purchase them himself, and when Kellie chose to take care of a sick woman's children for a few hours until other arrangements could be made.

As van Hooft (2006, p. 143) argues, 'taking responsibility' is a moral virtue because it involves a degree of self-sacrifice or risk. While the social workers who participated in this study were aware that their actions could possibly lead to conflict with managers or colleagues, their sense of responsibility to care led them to make the decisions they did. It is important to note, however, that such decisions were carefully considered, and arguments to justify their actions were prepared in case the social workers were confronted by authority figures. In spite of the tenacity that was evident in the social workers' stories of remaining committed to caring practice, this did not happen without taking a toll on participants. A commitment to caring practice also required a commitment to self-care, which is the focus of the next section of this chapter.

## **Doing care by incorporating self-care**

The findings indicate that the care social workers demonstrated in their practice involved considering and attending to certain limits and boundaries in order to ensure that they also took care of themselves. These findings support Noddings' (1995, p. 26) contention that the relational aspect of an ethic of care 'does not separate self and other in caring'. She argues that it is not possible to continue to care if the person doing the caring is diminished due to feelings of being overwhelmed and a lack of support from either the person one is caring for or from others. In order to continue to care it is sometimes necessary to 'free oneself to whatever degree one must to remain minimally, but actually caring' (Noddings, 1995, p.27).

Awareness that the constant day-to-day struggle of hearing difficult stories, fighting the barriers of the organisational and political context, and dealing with difficulties in their own lives made social workers aware of the need to attend to their own self-care. The ways they did this included taking time off, going for a short walk during work hours, seeking professional supervision and making time for hobbies, and family and friends outside of work time. Most of these strategies for maintaining self-care were not only employed as a way of caring for themselves, but also so that the social workers could continue to care for their clients in a meaningful way. They did not view self-care as an excuse to not care about and for their clients, but rather as a necessary component of their role as caring workers.

A couple of participants did express concerns that from their observations some social workers do use self-care as an excuse to distance themselves from their clients, believing that it was used as an avoidance tactic by them. Therefore, this study shows several sides to the concept of self-care. Some participants viewed self-care as necessary to continue to care for their clients and others viewed it as necessary to maintain a sense of their own comfort and wellbeing. When self-care became an excuse for not caring for clients, or when self-care overrode care towards clients, it was thought to be problematic. While scholars (Weekes 2014; Lee & Miller 2013; Alkema, Linton & Davies 2008; Lloyd, King & Chenoweth 2002) who have studied self-care in social work practice do briefly acknowledge the impact that



‘stress’, ‘burnout’ and ‘compassion fatigue’ have on the social workers’ ability to meet the needs of their clients, the predominant focus is on the impact of a lack of self-care on social workers and organisations. No direct link is made between self-care and an ethic of care in social work practice. The findings of my research suggest that the impact of a lack of self-care on social workers’ abilities to care for clients is as important as the wellbeing of the social worker.

In summary, the social workers who participated in this study ‘did care’ in a myriad of ways. They cared by connecting with clients, ‘being there’, advocating for clients and challenging the obstacles to caring practice, and intervening in the lives of their clients only when they considered it to be absolutely necessary or when it was perceived to be the most caring thing to do. They cared by ensuring that they looked after themselves, so that they were mentally and physically in a position to continue to care for their clients. I now progress this chapter by answering how client participants experienced care in direct social work practice.

## **Clients’ Experiences of Care in Direct Social Work Practice**

The findings from the client participant interviews in this research shared many similarities with the findings from social worker participant interviews in terms of how they thought about care. Clients’ experiences were not always positive, however; many had experienced uncaring practice by social workers. On the whole the positive experiences of caring social work practice were in line with the social workers’ descriptions of ‘doing’ care in their practice. There were a couple of significant differences between the two participant groups, however. The frequent experiences of ‘uncaring’ social work practice, and the importance clients placed on trusting their social worker were the most significant findings evident in the client data. I begin this section by discussing client experiences of ‘caring’ direct social work practice.

## **Experiences of ‘caring’ social work practice**

The clients who participated in this study were very clear about what care looked like in direct social work practice, with most of the features attributed to caring practice supporting theories of care identified in the nursing literature (Montgomery 1993; Leininger 1981; Mayeroff 1971). Mayeroff’s (1971) qualities of patience, honesty, trust and hope were all important pre-requisites to caring practice according to the clients who participated in this study. The importance of a caring presence as discussed by Engebretson (2004) and Leininger (1981) is also apparent in the ways clients spoke about care in this research. Clients strongly valued knowing that the social worker was ‘there’ for them, and willing to ‘just be in the moment’, demonstrating empathy and compassion, and responding to needs as they arose without judgment or any pre-conceived agenda.

As the findings show in Chapter 7, being treated as an individual with unique needs, rather than as a number or a member of a particularly category of problems, was crucial to clients feeling care. These findings are consistent with research conducted by nursing scholars (Morrison 1991; Riemen 1986), as well as social work academics (Beresford, Adshead & Croft 2007; Maiter, Palmer & Manji 2006; Drake 1994). For example, the importance the clients placed on the ‘little things’, such as a light touch on the arm, concern for physical comfort, a small gift or an extra visit or phone call, supported nursing students’ perceptions of care as reported in Adamski, Parsons and Hooper’s (2009) research.

The value of listening as a key feature of a caring presence was highlighted continually by the clients who participated in this research. Clients found it invaluable to have someone to talk to and air their problems, often for the first time. Furthermore, talking about their problems helped some participants to become clear in their own mind about their situation and possible solutions. These findings reflect Montgomery’s (1993) ‘transformative effects of care’, that result in clients shifting from a state of feeling ‘stuck’ and worthless, to a position of feeling empowered and full of hope. When social workers listened with genuine interest and curiosity without making assumptions, clients felt understood, valued and ultimately cared for. Participants who did not feel listened to did not generally believe that the social

workers were caring. Instead, like the clients in previous studies (Beresford, Adshead & Croft 2007; Maiter, Palmer & Manji 2006; Drake 1994), they felt that they were not given a voice; they felt judged, and they felt as if they did not matter.

### **Experiences of ‘uncaring’ social work practice**

Clients who participated in this study were equally clear when articulating uncaring social work practice. In common with Riemen’s (1986) research on patients’ views of caring nursing practice, many of the clients in this study launched into accounts of uncaring interactions before speaking about the more caring experiences. The clients often spoke about uncaring practice prior to being asked questions about this. These emotive stories were indicative of the considerable effect that unpleasant and even traumatic experiences of uncaring practice had left behind.

Similar to experiences reported by Beresford, Adshead and Croft (2007) and Holland (2010), clients in this study reported uncaring social workers to be cold, judgmental, critical, intrusive, manipulative, inattentive to their needs and more focused on ‘getting the job done’ as quickly as possible than spending time listening and showing empathy and compassion. Examples of such practice were common throughout the client stories, suggesting that along with an absence of care in the practice of some of the social workers clients had worked with, existing ethical guidelines were not always upheld. Principles contained in codes of ethics, such as respect for human dignity and worth, unconditional positive regard and acceptance of diversity were also breached at times. Luke’s experience of being judged by his social worker for excessive alcohol consumption without any consideration of the contributing factors demonstrated a lack of empathy and compassion, and only served to make Luke feel worthless. Likewise, when Eve was told by her social worker that she was suffering from ‘Cinderella complex’ she felt that her experiences of abuse and trauma were severely undermined and that she was disrespected as a person.

It is evident that the dimensions of care promoted by Tronto (1993) were absent in the clients’ stories of uncaring practice. Attentiveness, responsibility, competence,

responsiveness and integrity were lacking. When clients did not feel that they were being listened to or that the social worker was not being attentive to their needs they did not recognise the presence of care. When social workers placed all responsibility on the client to effect change, without consideration of the complexity of problems or existing structural inequalities, care was not recognised. When clients believed that their social workers did not demonstrate competence in their practice, particularly those clients who placed significant value on the practical aspects of practice (completing forms, advocating for clients, and arranging appointments and referrals) they viewed this as a lack of care. Accounts of social workers failing to respond to needs as a result of not listening or making assumptions about what was in the client's best interest, were seen to indicate an absence of care. Client narratives that illustrated incongruence between the attitudes and actions of social workers indicated a lack of integrity, and therefore a lack of care.

It is evident that the participants initially expected social workers to demonstrate care in their approach and when this did not happen, feelings such as worthlessness, hopelessness, anger and mistrust were engendered. The more uncaring the experiences the participants encountered, the more likely they were to lose expectations of care and less likely to willingly engage with social workers in the future. For those who did encounter a caring social worker after a long line of social workers who appeared not to care, it was a pleasant surprise. Even then, a sense of trust was something that took time to re-build and could easily be dismantled. I now discuss the important role of trust in caring social work practice.

### **The crucial role of trust in experiences of care**

Participants were hesitant to allow a relationship with their social worker to form until they gained a sense of trust in their worker. Small acts of care demonstrated to clients that they were valued and this built trust. It was important to clients that they did not feel judged. It was crucial to them that their social worker was being honest and genuine at all times, that they followed through on promises and that limits to confidentiality were made clear. When trust was built clients allowed a deeper caring relationship to form. While there is no direct mention of this in the literature, studies with social work clients conducted by Beresford, Adshead and Croft (2008,

2007) indicated that negative views of social workers as being manipulative, controlling, threatening and intrusive signalled a lack of trust. Beresford, Adshead and Croft (2008, 2007) found that for some clients when relationships were built and clients felt valued by their social workers, they in turn valued the relationship, indicating a renewed sense of trust in spite of past negative experiences with social workers. These findings support arguments posed by Baier (1986) and Sevenhuijsen (2003) that trust is a key component of caring relationships. It is important to note here that the clients were not passive recipients of care. They chose how much to share with their social worker and how much to let them form a caring connection, with such decisions largely being dependent on how much they trusted the social worker. Thus, a strong message from clients to social workers is that building trust is vital and it should not be assumed that clients will automatically trust a social worker.

While narratives about limits and boundaries to care suggested that the social worker participants of this research did not always trust their clients, they did not reflect knowledge that clients did not always trust them. Either it was not something they had thought about, or they took for granted that clients would trust them by virtue of their professional role. They strongly promoted the importance of being honest and genuine with their clients, but they did not appear to see the link between trust and honesty – that clients were only likely to believe that social workers were being honest and genuine if they trusted them.

Issues of trust were particularly evident in the findings from clients experiencing mental health issues. On the whole, these participants did not speak of the rich experiences of care that other participants did. While practical support, such as assistance with completing forms, referrals to specialists and attending appointments with clients was considered helpful, these clients did not indicate that a deep caring relationship often developed with their social workers. The care they received appeared to occur at a surface level. At the same time, these participants did not seem to have the same expectations as other participants about care. They indicated that they were satisfied getting their practical needs met and they valued being respected over being cared for. It was difficult to ascertain the reasons for the considerable difference between the experiences and expectations of this cohort and

other clients who participated in this study. In part, the findings indicate that these clients chose to distance themselves from their social workers, demonstrating a reluctance to become involved in caring relationships due to a lack of trust. This was the case when clients felt that the social worker was not being genuine or ‘real’. Scott and Nicky both clarified that this lack of trust was due in part to a fear of being admitted to hospital if they divulged too much. This fear is validated in the literature (Wyder, Bland & Crompton; Gilbert, Rose & Slade 2008; Brophy & Ring 2004) that confirms that negative experiences of involuntary admission are ubiquitous. Mental health patients often feel stigmatised and powerless. They experience distress and trauma as a result of treatment from medical professionals and being separated from their home, family, friends and pets. The findings of my research raise more questions than they answer as to why the experiences of care for mental health clients were different to other participants in this study and why trust seemed to be difficult to build. This indicated an important need for further research in this area. My contribution to thinking about care in relation to mental health social work is that trust is an important component of practice when working with this client group, and warrants further exploration. Any attempt to interpret these findings further here, based on the limited data available would potentially simplify and minimise the complex lived experiences of these participants.

While trust is not a concept that is frequently linked to ethic of care theory, the findings from this study show that trust or lack of trust had a major impact on clients’ perceptions of caring practice, as well as their willingness to develop relationships with and divulge information to social workers. Closely aligned with trust, and a common thematic thread that ran through all of the findings was the idea of ‘valuing the other’ and I discuss this in the following section.

## **Valuing the Other as the Central Component of Caring Social Work Practice**

The findings from this study indicate that applying an ethic of care to social work practice requires something other than applying the principles and elements outlined

in current ethic of care theory. As many participants pointed out, true care is difficult to describe, as it is often something that is ‘felt’ and as a result it is difficult to speak about in concrete terms. While many of the features of care that have been discussed from the findings thus far in this chapter, such as empathy, compassion, patience, understanding, deep listening, non-judgment, responsiveness, and concern for the other can and do demonstrate care, there is also something deeper that participants seemed to be referring to when they described caring interactions, yet found difficult to describe. Archibald spoke about how he liked it when his social worker told him he was lazy. He believed that this indicated that she cared about him. When asked why he perceived this as caring rather than judgmental he was not sure how to respond, simply saying ‘I don’t know, it’s not like it’s a compliment or anything, but I know she says it because she cares’. It seems that there was something about the way that the social worker conveyed care, something that was difficult to explain, that resulted in Archibald feeling cared for rather than offended by the honest comments he received. Another client, Jessie, knew when a social worker was pretending to care, when the care was not genuine. Jessie could not describe this, other than saying she ‘just knew’. Therefore, clients’ experiences of care appeared to be dependent on the dynamics that existed within the relationship and the genuineness of the care that was being offered. These findings may be explained by Gastmans’ (1999) contention that the basis of care is a moral attitude, that is, an attitude of valuing the other. While his theory has been related to care in nursing, it can be applied to care in social work and correlates to the views of social work clients in this study who stated that feeling valued is a pre-requisite to demonstrations of care. Gastmans (1999, p. 218) describes a caring attitude in the following way:

Nurses build up a caring relationship with a patient because they consider the patient to be important as a person. Care places a person in a situation where he or she can appear as meaningful. Concrete caring actions only have an ethical value in the light of the quality of the caring attitude of which they are the expression.

This view strongly aligns with Bauman’s (1994, 1993) argument that moral responsibility begins with the recognition that above all else, the ‘other’ is a valuable, fellow human being. Social worker Cloudy Bay explicitly supported these ideas when he said ‘Care is about valuing the other as an important human being’,

and other social workers made similar comments to support this view. They spoke about how they would often do that little bit extra, and outside of what was expected as a part of their role. Examples include Cloudy Bay helping a client jump-start a car, Lou making a client's bed and Kellie watching young children for their sick mother until other arrangements could be made. These findings support studies conducted in the nursing profession (Adamski, Parsons & Hooper 2009; Montgomery 1993), which identified listening, non-judgment, competent practice and a preparedness to give extra care and attention, that was outside of the expected role as key to caring practice. The powerful impact of feeling valued is clearly visible in experiences related in this study. When clients felt valued they were more inclined to open up, to believe in their abilities to move forward and to take action that led to positive change in their lives.

These findings also extend the arguments presented in the literature about how virtue ethics compliments ethic of care theory (Thomas 2011; Sander-Staudt 2006; Halwani 2003; Slote 1998). Prominent authors of ethic of care theory (Held 2005; Noddings 1984; Gilligan 1982) argue that virtue ethics and an ethic of care are not compatible due to the former placing an emphasis on character traits and the latter emphasising relationships. The findings of my research show that a caring attitude and genuine concern and compassion are as essential as the dynamics of the relationship in terms of defining and recognising care in direct social work practice. The social workers who participated in this research described a 'caring orientation' as being of vital importance for care to be experienced by clients, and client participants paid particular attention to the demeanour that social workers brought with them into the relationship.

In summary, participants in this study indicated that experiences of true care were not superficial and could not be experienced by social workers simply following ethical guidelines. A deep experience of care was not merely instrumental, but emerged from a moral attitude that aligns with virtue ethics that involved a commitment to valuing the client. Valuing the other incorporates all of the remaining significant findings from this research that inform an ethic of care for direct social work professional practice, contributing knowledge to how care can be practised as an ethic in direct social work practice. Bauman clearly speaks about the



importance of ‘valuing the other’ in his moral theory and while he uses this as his basis for recommendations for the social work profession he does not specifically relate it to ethic of care theory. Ethic of care theorists (Tronto 2013, 1993; Held 2006; Gilligan 2002, 1982; Noddings 1984) come close at times to capturing the idea of ‘valuing the other’ however they do not explicitly mention this concept. According to the findings of this research, trust, Tronto’s (1993) five dimensions of care, a virtue of caring, continual evaluation of caring practice, balancing care and justice, moral courage and a commitment to taking responsibility for caring direct social work practice all assist social workers to value the other through care. The findings of this research support Stanford’s (2007, p. 258) contention that ‘care grounded in our compassionate recognition of others...could become an organising framework for practice within which our moral identities as social workers would be clearly defined’.

## **Concluding Comments to the Chapter**

In this chapter I have answered the research question, explaining how thinking about, doing and experiencing care in direct social work practice informs an ethic of care in the professional context. Findings indicate that current ethic of care theory, particularly the work of Tronto (1993), is an important part of caring in direct social work practice. Demonstrations of care involved both ‘caring about’ and ‘caring for’ clients. Tronto’s (1993) view that an ethic of care and an ethic of justice are intertwined is supported by the findings in this research. Features of caring social work practice described by participants strongly aligned with research findings from nursing scholars, indicating that the nursing literature offers valuable resources for understanding how care can be applied to social work practice.

Participants’ views and examples demonstrate there is a need for a new moral framework to be included in social work practice – a framework that strongly incorporates an ethic of care. The difficulties the neoliberal organisational context and New Public Management pose to caring social work practice required social workers to draw on courage and a sense of moral responsibility in order to ensure that care remained central to their practice. Trust was perceived by social work

clients to be a key component of caring practice. The emphasis research participants of this study placed on trust and ideas that are compatible with virtue ethics provides the social work profession with a new way of thinking about how an ethic of care can be enacted in direct social work practice. Ultimately the answer to the research question and the most significant finding of this study is that an ethic of care for direct social work practice is informed by the concept of ‘valuing the other’ and that this occurs in a multitude of ways, not least of all being the importance of building trust with clients. The implications of these results for future direct social work practice, research and education are discussed in the following and final chapter of this thesis, and a practice theory for direct social work practice is proposed.

# **Chapter 9: A Practice Theory for an Ethic of Care in Direct Social Work Practice and Concluding Comments**

In my hours of greatest vulnerability, I will need more than skilled hands. I will also need a caring heart. Is this really too much for one human being to ask from another human being in his or her time of greatest need? A moral imposition? Or is it simply what we should expect from each other? (Tong 1998, p. 151).

## **Introduction to the Chapter**

The main conclusion of my study is that care is highly valued by social workers and social work clients alike, and participants' accounts of thinking about, doing and experiencing care provides important information for informing how an ethic of care can realistically be applied to direct social work practice. This study has shown that caring social work practice does not only add an extra dimension to practice, is not simply 'nice' to do, but it is an integral and essential component of a meaningful experience. This research has also demonstrated that in spite of the challenges that the current professional context presents, caring practices can thrive when social workers are committed, tenacious and courageous. According to this research an ethic of care for direct social work practice requires a commitment to valuing the other, the virtue of caring, trust, the implementation of Tronto's five dimensions of care, continual evaluation of caring practice and an awareness of how a care approach can also pay attention to issues of social justice.

As mentioned in Chapter 2, the main criticisms of the inclusion of an ethic of care for social work practice are: care does not assure the 'rightness' of an action (Featherstone 2010); the profession's focus on justice may be neglected; and care reinforces rather than interrogates difference (Featherstone & Morris 2012). Such concerns are not sufficient enough for it to be avoided or disregarded. This is particularly the case when considering the significantly harmful impact that uncaring

practice can have on clients, as identified in my study and supported by other research (Holland 2010; Adshead & Croft 2008, 2007; Bland, Laragy, Giles & Scott 2006). My study demonstrates that when clients experienced uncaring practice it breached their sense of trust of social workers, it made them feel devalued and it resulted in them being reluctant to seek future support from social workers. This study demonstrates that it is important to be able to incorporate an ethic of care into social work practice that both attends to the needs of clients as well as maintaining core social work principles of social justice, self-determination and practice competence.

While the contextual and relational nature of an ethic of care means that there can be no prescription given for caring practice, this study has made it possible for me to offer a practice theory that could be a useful guide for social workers who aim to ensure that care is an integral part of their practice, in a way that does not dilute their professional integrity. I propose a practice theory that is care-centred in its approach. I begin this chapter by arguing that this study's findings support the idea that social workers need to become familiar with ethic of care theory, in particular Tronto's (1993) five dimensions of an ethic of care. I argue that 'building trust' should be added to these basic dimensions of an ethic of care when applying the framework to direct social work practice. I then make some additional recommendations for applying an ethic of care to direct social work practice. I claim that my research suggests that social work will benefit from situating an ethic of care in the moral framework of virtue ethics. I then highlight how the results of my study clarify the necessity of evaluating caring social work practice through critical reflection and client feedback. The results of this research stress the importance of balancing considerations of care and justice when attending to ethical dilemmas in practice and pose some useful questions that may assist in weighing up ethical dilemmas in social work practice. The chapter concludes by acknowledging the limitations of this research and by explaining possibilities and recommendations for future research, social work education and professional development training.

# Care-Centred Social Work Practice: A Practice Theory

In this section I state that the findings of this study support the idea that direct social work practice should be ‘care-centred’. Although the social workers who participated in this research highlighted care as an important part of their practice, and they were able to articulate how they practiced care, it was spoken about as something they did outside of general professional and organisational expectations. This supports arguments from social work academics (Gray 2010; Meagher & Parton 2004; Parton 2003), that care remains on the periphery of contemporary social work education, theory and codes of ethics. In this research I have identified a need to return care to ‘the very heart of social work practice’ (Parton 2003, p. 10), in the form of an ethic of care that is in line with the professional context of social work. Care-centred social work would include and add to the work of Tronto (2013; 1993) by incorporating her four phases and five ethical dimensions of care.

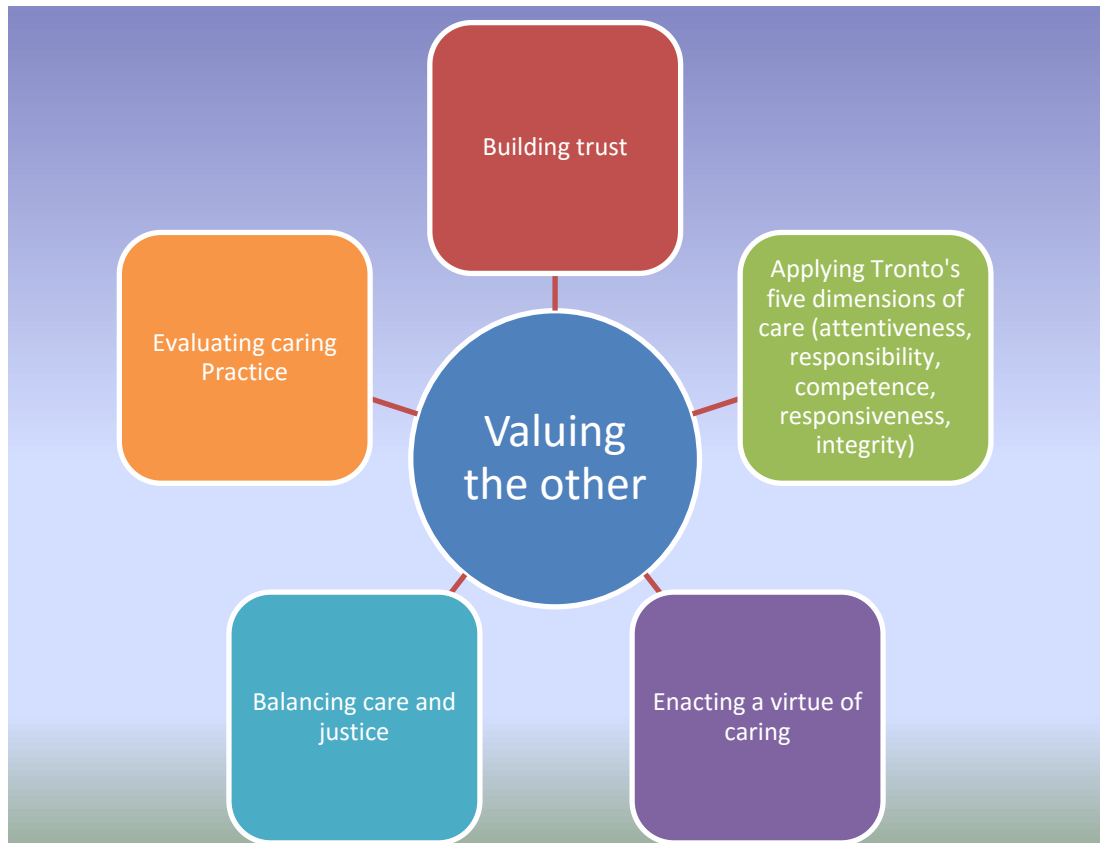
In developing a care-centred practice theory for direct social work practice, it became clear that implicit in the findings of my research was the idea that ‘valuing the other’ was an overriding finding of what it means to care in practice and that nothing else makes sense without this foundational aspect of care. I argue that practising an ethic of care in direct social work practice requires demonstrating to the client that they are valued through trust building, practising a virtue of caring, evaluating care in practice and balancing care and justice. Figure 1 illustrates my care-centred practice theory. I now explain each of the components of care-centred practice that are informed by the results of this research.

## **Applying Tronto’s five dimensions of care into direct social work practice.**

This research confirmed that Tronto’s (1993) five ethical dimensions of care are relevant to caring social work practice, and I propose that Tronto’s (1993) theory should form the basis of a care-centred direct social work practice. The dimensions of attentiveness, responsibility, competence, responsiveness and integrity are crucial to caring social work practice. Each of these dimensions were outlined in detail in

Chapter 2 of this thesis, reflected throughout the findings of this research and discussed further in Chapter 8.

**Figure 1: A care-centred practice theory for direct social work practice.**



## Trust building

In addition to Tronto's five dimensions of care, I propose 'trust building' as a dimension of care in direct social work practice. The clients who participated in this research argued that social workers cannot take for granted that clients will trust them simply by virtue of their professional role. As Mayeroff (1971, p. 9) has argued, trust must be earned: it is not a right to be trusted, but a privilege. Clients in this study were strong in their claims that social workers need to understand that it can take time for clients to trust and to feel secure enough to be open and honest about their problems and feelings. Trust building requires social workers to value their clients and to be patient. The findings of this study showed that clients were more likely to trust their social workers when they felt that their social worker

believed in and trusted them in return. Practising care from a virtue ethics perspective may promote trust between social workers and their clients.

### **Enacting a virtue of caring**

According to McBeath and Webb (2002, p. 1020) the relevance of virtue ethics to social work practice is clear. They argue:

The basic question is not what is good social work, but rather what is a good social worker? Such an ethics gives moral meaning to modes of practice... Doing a task well is not merely a matter of rule-following; expressed in it are the skills and virtues of the persons. This point may be used against the mantra of 'good practice'

Therefore, in order for social workers to genuinely practice an ethic of care in their direct practice, they need to think beyond the instrumental elements of care to the deeper aspects of care that participants talked about yet found difficult to explain. The basis of care may best be described as the demonstration of care as a virtue. Social workers could benefit from thinking about how they reflect a caring response, not merely as a function of ethical or organisational imperatives, but also as an aspect of being a caring human being. Banks and Gallagher (2009, p. 100) use the term 'moral imagination' to describe how a virtue of caring can be built and expressed. A 'moral imagination' involves beginning each client interaction with an open, empathic stance towards the client and a readiness to listen and respond prior to gaining any knowledge about the clients' circumstances (Banks & Gallagher 2009, p. 100). This idea may prove to be a helpful addition to Tronto's (1993) dimensions of an ethic of care in promoting the caring social worker. It involves an unconditional commitment to maintain a caring stance. The 'moral imagination' requires an 'initial orientation' towards the client, requiring the social worker to prepare to act as a caring person (Banks & Gallagher 2009, p. 100). In this sense a caring virtue can be learnt. It does not have to be something that comes naturally although this may prove to be the case in time. Nor does it have to be a quality that only certain people possess. As this study reveals, a virtue of caring cannot always be put into action without courage, commitment and a preparedness to take risks along the way. A virtue of caring is not prescriptive and cannot be measured in a scientific way. It can only be assessed through evaluation in the form of reflection and feedback from clients.

## **Evaluating caring social work practice**

Continual evaluation is required in order for social workers to determine whether they are practising from a place of care and whether clients perceive practice as caring. The accounts of uncaring practice from clients who participated in this research suggest that social workers need to critically reflect on their practice as well as seek feedback from clients. Fook and Gardner (2007, p. 46) contend that the aim of critical reflection is to 'shake up thinking', which then enables a person to challenge ingrained assumptions and consider new, more appropriate and productive ways of thinking and acting. Fook and Gardner (2007, p. 75) pose some useful questions for critically reflective practice. While their questions do not use the term 'care', I have reframed them to relate specifically to caring social work practice:

1. Are there gaps or contradictions between what I say I do about care and what is implied by what I do?
2. What is behind these contradictions in my caring practice and where do they come from?
3. What needs to change about my thinking or practice of care to handle the contradictions?
4. How did I influence the situation as an episode of care through: my presence, my actions, my pre-conceptions or assumptions, other people's perceptions of me, my physical well-being on the day?
5. What might be the perspective of other players of my practice of care in the situation? Why is mine different?
6. How do my personal experiences and beliefs from my social context interact with my care in this situation?
7. What functions do my beliefs play in how I do care?

Evaluating care requires seeking and encouraging feedback from clients. The clients who participated in this study did not all perceive care in the same way, with some describing care as simply assisting with practical needs and respecting their right to choose not to disclose personal feelings and information. Some described care as a preparedness to listen and demonstrate understanding, while others appreciated advice and direction. Therefore social workers should ascertain how caring practice is perceived by each client. A powerful statement when beginning work with a



client could be: 'It is important to me that you know that I care about you'. This statement could then be followed by a question such as: 'What would I need to do for you to know that I care?' Continuing to check with the client whether the time spent together has been helpful and asking how they feel things are going from time to time allows the client to have some power in the relationship and gives the social worker a chance to reassess and modify their approach if necessary. Some of the mental health clients pointed out that being respected was the aspect of care that they valued the most. Therefore, a caring approach towards these clients would be to value them by primarily showing respect and recognising their personal boundaries around privacy, and their right to only share information they were comfortable sharing. Sometimes the caring thing to do is also the fair and just thing to do, as argued in the next section of this practice theory for an ethic of care in direct social work practice.

## **Balancing care and justice in the professional social work context**

It is evident from the stories shared by participants in this research that holding care and justice in opposition to one another is unhelpful. Social justice is and should remain a key tenet of social work practice and care does not preclude justice. In Chapter 2 I reviewed literature (Held 2006, 2002; Heckman 1999; Jagger 1995; Tronto 1993) that argues that a complete ethical position requires considerations of both care and justice. There are times when the moral and ethical thing to do is to make a decision based on care and other times when the decision should be based on justice. Often the caring thing to do is the most just thing to do and vice versa. As Gilligan argues (2002, p. 683) often the two ways of thinking are simply two sides of the same coin, and as Tronto (1993) states, care is required for justice to be genuinely realised. While many of the social workers who participated in this study were guided by a commitment to care to justify the decisions they made in their practice, they also drew on their professional knowledge, commitment to social justice and legal principles in order to increase self-confidence in their decisions and strengthen their case.

In summary, my practice theory for an ethic of care in direct social work practice incorporates Tronto's four phases and five dimensions of an ethic of care, building trust, practising a virtue of caring, evaluating care in practice, and balancing care and justice in practice. I acknowledge that this research is not without limitations. These limitations are discussed in the next section of this chapter, along with implications and recommendations for future research and social work education.

## **Limitations and Recommendations for Future Research and Social Work Education**

The main strength of this study is that it provides an in-depth insight into the practice of care in the contemporary context of social work practice from the perspective of both social workers and social work clients. While care has recently become a topic of theoretical interest in social work, few attempts have been made to explore the direct practice context in empirical terms. The clients' perspective is particularly absent from research literature. As I noted in Chapter 3, concerns have been raised that care is at risk of being lost amidst the neoliberal ideologies that the social work profession is situated in (Dybicz 2012; Gray 2010; Parton 2003). This study has illuminated how caring practice can continue in contemporary direct social work practice.

A fundamental limitation that accompanies any qualitative methodology is the capacity for findings to be generalised across larger populations. In this sense these findings do not represent all social workers and social work clients. From a constructivist standpoint the intention of this research was to present and remain grounded in the lived experiences of participants. The research did not aim to make claims of universal truth, but to 'generate comprehensive and situated understandings of the research problem' (Rubin & Babbie 1997, p. 414). The strengths of qualitative studies, such as this one, are that they provide rich and meaningful data that can be used to contribute to theory building and identify areas for future exploration (Alston & Bowles 2003, p. 10). I have done this by proposing

a practice theory for care-centred direct social work practice and making recommendations for research and social work education and training.

A gap in this research was that none of the social workers who participated in this study were involved in child protection or criminal justice social work. Clients did not speak about experiences in these areas of practice. As discussed in Chapter 3, some empirical study about care has already been conducted in these fields of practice in regards to care (Bunting & Webb 2015; Gregory 2010; Holland 2010). It has been recognised that care is fundamental to practice in these areas, where interaction with social workers is often involuntary and positive outcomes are more likely when a caring approach that is in line with ethic of care theory is applied. The lack of trust that I identified from the mental health clients' accounts in this study provides further insight into the significance of valuing the client by enacting caring practice when working with involuntary clients.

It is important to consider that the social workers who expressed interest in participating in this study seemed to be drawn to the research topic and already held strong convictions that care is an important part of social work practice. The uncaring storyline so often evident in the clients' accounts may be largely absent from social workers stories for several reasons: they were already committed to caring practice; they justified their lack of care; or they may not have felt comfortable talking about the 'dark side' of care. The clients' accounts of care, or lack thereof, in social work practice provide another side to the mostly positive picture of caring practice presented by the social workers who participated in this research. Interviewing social workers who supervise students on field-work placement and/or qualified social workers about their observations of caring/uncaring practice may provide further valuable insights. Just as social workers who were already committed to caring practice may have been attracted to this study, the converse may also be true in regards to clients. It is important to consider that clients who had experienced a lack of care may have been attracted to the study in order to voice their concerns. A quantitative study of social workers and social work clients may be useful to determine whether these findings are supported across a larger population. Surveys that include questions that are informed by the findings of this research could be a useful method of exploring the topic on a broader scale.

The expectations of care from the mental health clients in this research were quite different to those of other participants. They were generally satisfied with practical support and spoke minimally about the relational aspects of care. A lack of trust in the social work profession in general clearly played a part in this finding. While it can be speculated that the often involuntary nature of mental health social work may have contributed to this finding, further research is necessary to determine other reasons. More research needs to be conducted in order to ascertain the care needs and experiences of clients who experience a mental illness. Studies that explore the concept of trust in more depth would be beneficial. Future studies could recruit a larger number of participants that capture a wide range of experiences of caring or uncaring practice in voluntary and involuntary mental health settings, and according to different types of mental health problems. An anonymous questionnaire that also allows for some individual, in-depth responses may be more appropriate than interviews about caring practice and a more effective means of eliciting responses about care. The findings from this research could inform the design of a questionnaire, with inclusion of questions about trust. Spending time building trusting relationships with these clients is vitally important for future qualitative research if social workers are to gain a realistic understanding of their lived experience of care. Enquiring about particular aspects of care that social workers and clients have highlighted as important, such as trust, listening, non-judgment, understanding and valuing the client may elicit more in-depth responses than enquiring about care in general.

The final limitation of this study relates to the absence of considerations of care in diverse cultural groups, including Indigenous Australians. This research was designed to explore care broadly across direct social work practice; it did not explore specific cultural aspects of care. Baltra-Ulloa (2013, pp. 99-100) argues that an ethic of care is vital for social workers when working with people from a variety of cultural backgrounds. She claims that the contextual nature of an ethic of care will enable practitioners to work *with* people from diverse cultural backgrounds in an authentic manner that considers unique needs and lived experiences – a way of working that focuses on relationship and mutual trust and transcends tokenistic, ‘white’ ideals such as cultural competence and cross-culturalism (Baltra-Ulloa (2013, p. 99). Baltra-Ulloa (2013, p. 99) contends that by employing an ethic of

care social work can dispense with current frameworks that sometimes reinforce difference. She says:

Social workers would no longer think of cross-culturalism as necessary, nor would they think of cultural sensitivity or cultural competence as tools for practice, but rather would be invested in ensuring people ‘care for’ one another and are ‘cared for’ by others (Baltra-Ulloa 2013, p. 99).

While Baltra-Ulloa (2013) highlights the potential value of an ethic of care when working with clients from various cultural groups no studies have yet been conducted that explore the views and experiences of people from diverse cultural groups in relation to care – the people who would be impacted by such practice. Therefore, there is scope for studies to be conducted in this area. It is important to ascertain whether people from non-white, non-western backgrounds view care in the same or different ways to the participants of this study.

### **Integrating a care-centred practice theory into social work education and professional development training**

While social workers did consider the care needs of their clients, most did this informally. Becoming conversant with the literature on ethic of care theory and considering my care-centred practice theory could assist social work students and experienced social workers to reflect on the role of care in ethical decision making. This could add a new dimension to their frameworks for practice and provide an adjunct to codes of ethics. Observing students’ practises of care on field placement, followed up by critical reflection of caring practice and feedback from fieldwork supervisors could be a useful addition to placement learning outcomes and assessment. The inclusion of ethic of care theory in curriculum content for all university social work programs could assist students to reflect on care and consider how it informs their frameworks for practice early in their training. I acknowledge that this may already be happening in some social work programs. A national research project that explores the inclusion of curriculum content on care and ethic of care theory in social work programs would help clarify the extent to which this may be the case. To meet the needs of qualified social workers, content could be delivered through professional development training. I propose that my care-centred

practice theory would provide a useful base for planning curriculum content and training.

## **Concluding Comments to the Chapter**

Throughout this thesis, I have addressed a growing concern expressed in contemporary literature that social work is at risk of losing sight of care in practice, primarily due to an increasing focus on evidence based practice and the influence of neoliberal ideologies. Fears have been raised that it has become progressively difficult for social workers to demonstrate care to clients when care is seen to be antithetical to individualistic notions that promote independence and self-responsibility. Until now research has been limited in terms of investigating what is actually happening ‘on the ground’ of social work practice. Thus, an important contribution of this study is that it provides evidence of how care is considered and enacted in everyday direct social work practice. While the social workers acknowledged the difficulties the professional context poses to care, their inspiring and courageous stories of care provide hope and confidence that social workers can and do transcend the barriers and constraints posed to care. On the other hand, client accounts of care were mixed. Many positive experiences were shared, along with many other experiences that indicated a lack of care. I have identified from the client findings that there is some basis for the fears expressed by social work scholars that caring practice may be in a precarious position. The views and experiences of the participants of this study offer a valuable contribution towards informing an ethic of care for social work practice. An ethic of care for direct social work practice requires perceiving care as a ‘virtue’, placing importance on continual evaluation of caring practice, developing trusting relationships, balancing a commitment to social justice with care, and ultimately demonstrating to the client that they are valued. This study illustrates that care needs to be returned to the centre of direct social work practice and social work education if the professions’ aim to make positive change in the lives of clients is to be achieved.

## Appendix 1: Letter of Invitation to Social Workers

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Date

Dear

My name is Jenny Hay and I am a PhD candidate in the School of Sociology and Social Work at the University of Tasmania in Launceston. My research is exploring the relevance of an ethic of care in social work practice. I am conducting this research as partial fulfilment of my PhD degree and this study will be completed under the supervision of Dr Sonya Stanford, lecturer in the School of Social Work at the University of Tasmania.

An ethic of care is an ethical stance which places an emphasis on relationships, emotions and the unique context of a situation. This can be seen to contrast with the more traditional ethic of justice which focuses on universal abstract rules and principles and informs most professional codes of ethics. While the concept of care has arguably been of core concern to social work since its inception, talk of care has become remarkably absent over the past few decades. Recent concern has been raised that care is being lost and devalued in the contemporary social work context which emphasises the importance of evidence based practice and professionalism. I am interested in speaking to you, as a social worker, about what the concept of care means to you and how you enact and experience care in your practice.

I have enclosed an information sheet and consent form for you to read. I feel it is important that you are informed of what will be involved in regards to your participation, as well as how any potential risks to you are managed and minimised. If you decide to participate I will request that you sign the consent form with me before we begin the interview.

If you are interested in participating in this research you can contact me on 0448 384822 or email [jhay@utas.edu.au](mailto:jhay@utas.edu.au). Thank you for taking the time to read this information.

Kind regards

Jenny Hay  
PhD Candidate (School of Sociology and Social Work, University of Tasmania).

## Appendix 2: Information Sheet for Social Workers

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This information sheet has been produced to explain to you what the research project is about and what your participation would involve. The information sheet is for you to keep and refer to at any time.

### **Title of project**

Exploring the relevance of an ethic of care in contemporary social work practice: Social workers' and clients' perspectives.

### **Who is involved in this study?**

My name is Jenny Hay. I am a social worker and I am completing my post graduate studies in Social Work as a PhD student through the University of Tasmania. This study is being conducted in partial fulfilment of my PhD degree and is being completed under the supervision of Dr Sonya Stanford, lecturer in the School of Social Work at the University of Tasmania. I have chosen this area of research because of my interest in the concept of care in social work practice.

### **Why is this research being done?**

While care is a taken for granted part of social work practice, it is not something which is talked about a lot in the profession. I am interested in speaking to both social workers and the people that visit social workers to gain an understanding of how important care is to the people I speak to and how it is shown in social work interactions. I am conducting this research so that the social work profession can also gain this understanding and so that social workers can meet the needs of the clients we work with.

### **Are there any benefits for me?**

This is an opportunity to have a voice and share your experiences of working with clients. It is also a chance to make a contribution to the field of social work. The results will provide further information and understanding of the role of care in



social work practice and potentially contribute towards changes to the way in which social workers practice in the future.

### **What does this research involve?**

If you would like to be involved in this research I will be asking you to participate in an interview with me of around 1½ hours duration. The location and time of the interview can be arranged to suit us both. I am interested in finding out what care means to you in relation to your practice and whether you believe it is an important part of practice. I will also be asking you to talk about a practice situation as an example of your practice and the thoughts, feelings and situations you found yourself in. It is important that you understand that my role is not to judge or criticize your actions in any way. You are also not obliged to answer any questions that you do not feel comfortable with. With your permission, your interview will be audio recorded. This recording will be typed up and a copy will be sent to you to check if there is anything you would like to add, change or remove before I use it in the research.

I may also request a second interview with you several weeks after the first. There may be certain issues and ideas that emerge while interviewing participants and potentially raise more questions and I would like all participants to have a chance to answer them. If a second interview is agreed to it is likely to be shorter than the first. I will also provide you with a summary of the final report when the research is completed.

### **Who is eligible to participate in this research?**

You are welcome to participate in this study if you are eligible for membership with the AASW and have worked for a minimum period of one year since obtaining your qualification.

### **How to express interest in participating**

You can call me on my mobile no 0448 384822 or email me at [jhay@utas.edu.au](mailto:jhay@utas.edu.au) to discuss the research further or clarify any concerns. If I do not answer my phone please feel free to leave a message and I will call you back as soon as possible. If I do answer immediately I am also happy to call you back so as to save you telephone

costs. Your contact with me will be treated respectfully and with confidentiality at all times.

### **How is my identity protected?**

It is important to let you know that I am aware that it is important that your identity is protected. In order to minimise the chances that you will be identified I will transcribe all interviews in the privacy of my office at the Launceston University Campus. Only the chief investigator and supervisor of this research will have access to the recordings and all transcripts and recordings will be kept in a locked filing cabinet or on a password protected computer. All data will be deleted or shredded and destroyed after five years. Your anonymity will also be maintained by giving your interview and transcript a false name which you can choose if you wish to do so. Your consent form will also be kept separately from your transcript. Also to prevent anyone from being able to identify you from the completed thesis or future articles you are invited to delete anything from the transcript that you believe may identify you.

### **What happens if participation results in emotional discomfort?**

I do not expect the interview to result in any significant emotional distress. However, I also realize that talking about experiences may bring up memories of difficult moments in your practice. I am also aware that you may feel embarrassed or uncertain about the significance of talking about this rather personal aspect of practice. You are free to refuse to answer any questions that you do not feel comfortable with. If you feel uncomfortable, anxious or upset at any time during the interview, you are welcome to stop the interview and request that the recorder be turned off. You can then decide whether you just need a break, would like to change the topic, finish the interview or even withdraw from the research. As a counsellor I am confident that I can interview you in a sensitive and respectful manner where you feel supported and safe if you do feel any distress. If at any time after the interview you continue to feel anxious or upset you may access the following free support services.

**Lifeline telephone counselling**

**13 11 14**

**Anglicare**

**63 346060**

**What happens if I feel unwell or tired during the interview?**

If you are feeling unwell on the day of the interview please do not hesitate to contact me and schedule another time. If during the interview you begin to feel unwell or it becomes too tiring we can take a break or discontinue the interview. All you need to do is let me know and we will discuss the options.

It is also important to understand that participation in this study is purely voluntary and you will not be judged or disadvantaged in any way if you decide not to participate or continue to participate.

**Statement regarding approval**

Ethics approval was granted for this research (Reference No: H11854) from the Human Research Ethics Committee (Tasmania) Network on 6th July 2011.

**Who else can you contact if you have any queries or concerns?**

This study has been approved by the Tasmanian Social Science Human Research Ethics Committee. If you have any concerns or complaints about the conduct of this study you may contact the Executive Officer of the Human Research Ethics Committee (Tasmania) Network on (03) 6226 2763 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote H11854.

For general queries or if you would like to contact me to participate, I am available via email [jhay@utas.edu.au](mailto:jhay@utas.edu.au) or on mobile number 0448 384822. A statement of informed consent will be made available to all potential participants.

Thank you for taking the time to read this information.

Jenny Hay  
PhD Candidate (School of Sociology and Social Work, University of Tasmania).

## Appendix 3: Consent Form for Social Workers

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### **“Exploring the Relevance of an Ethic of Care in Contemporary Social Work Practice: Social Workers’ and Clients’ Perspectives.”**

1. I have read and understood the “Information Sheet” for this project.
2. I understand that participation in this study will require being involved in an interview which will take approximately one and a half hours and that this interview will be recorded.
3. I understand that I will be given the opportunity to review the transcript of the recorded interview and may choose to change or delete any part of the interview at my discretion.
4. The nature and possible effects of this study have been explained to me.
5. I understand that the following risks are involved.
  - I could potentially be identified in the research.
  - I may feel embarrassed talking about my work.
  - I may feel some emotional discomfort when talking about practice situations.
  - I may find the interview process tiring.

I understand that a number of precautions have been taken to avoid these risks.
6. I understand that the research data will be securely stored on the University of Tasmania premises for at least five years, and then will be destroyed.
7. Any questions that I have asked have been answered to my satisfaction.
8. I agree that research data gathered from me for the study may be published provided that I cannot be identified as a participant.
9. I understand that the researchers will maintain my identity confidential and that any

10. Information I supply to the researcher(s) will be used only for the purposes of the research.
11. I agree to participation in this investigation and understand that I may withdraw at any time without any effects, and if I so wish, may request that any data I have supplied to date be withdrawn from the research.
12. I understand that I am obligated to respect the privacy of the identities and information of people and agencies that feature in my practice example.

Name of Participant:

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Signature:

Date:

---

### **Statement by Investigator**

I have explained this project and the implications of participation in it to this volunteer and

I believe that the consent is informed and that he/she understands the implications of participation.

Name of Investigator:

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Signature of Investigator: \_\_\_\_\_

Date: \_\_\_\_\_

I would like to receive a copy of the results of the study

Yes

No

## Appendix 4: Flyer for Client Recruitment

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### Have you thought about how your social worker cares?

Consider how you would answer these questions?

- What does it mean for a social worker to show that they care about you?
- What sorts of experiences have you had when visiting a social worker in terms of care?



These questions form the basis of a research Project that is being done by Jenny Hay, from the School of Sociology and Social work at the University of Tasmania. You could be a participant in this research.

You can participate if you:

- Have seen a social worker within Tasmania during the past 12 months; and
- You are over 18 years of age; and
- You are currently living in Tasmania

How will I know if I have seen a social worker?

- Not all counsellors or caseworkers have a social work qualification.
- You can be sure the person you saw is a qualified social worker if their title in their organisation is 'social worker' or if they have the letters BSW or AASW beside their name.
- If unsure you may wish to contact the organisation you visited to check this.

Will I get paid?

You will be given a \$50 Coles-Myer voucher as a thank you gift.

What will the research involve?

You will meet with Jenny for up to an hour and a half and talk about your experiences of care when working with a social worker.

What do I do if I am interested in participating?

You need to read the information sheet about the research and sign a consent Form. All of these things can be done by calling Jenny on 0448 384822 or email [jhay@utas.edu.au](mailto:jhay@utas.edu.au).

Do I have to participate?

No, there is no obligation to participate and you may withdraw from participation at any time.

## Appendix 5: Letter to Services Seeking Recruitment Support

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Date

Dear

My name is Jenny Hay and I am a PhD candidate in the School of Sociology and Social Work at the University of Tasmania in Launceston. My research is exploring the relevance of an ethic of care in social work practice. I am completing this research in partial fulfilment of my PhD degree under the supervision of Dr Sonya Stanford, lecturer in the School of Social Work at the University of Tasmania.

An ethic of care is an ethical stance which places an emphasis on relationships, emotions and the unique context of a situation. This can be seen to contrast with the more traditional ethic of justice which focuses on universal abstract rules and principles and informs most professional codes of ethics. While the concept of care has arguably been of core concern to social work since its inception, talk of care has become remarkably absent over the past few decades. Recent concern has been raised that care is being lost and devalued in the contemporary social work context which emphasises the importance of evidence based practice and professionalism. I am wishing to conduct in-depth interviews with social workers and social work clients in an attempt to understand the meaning attributed to the concept of care as well as how care is enacted and experienced in social work practice. It is my aim to document the perceptions of my participants in order to inform the social work profession as a whole. The purpose of this study is to investigate the experiences and views of social workers and how their views relate to the profession; **not** to investigate the organisations they work for.

My purpose in writing to you is to request assistance in recruiting client participants for this study. In order to meet the ethical guidelines set out by the university it is important that clients do not feel coerced to participate and it is for this reason that I have chosen not to recruit directly through the social workers individual clients work

with. If you are interested in supporting this research by assisting me with recruitment, the process will be as follows:

- I will provide information packs to be sent to potential participants. These include an information sheet, a statement of informed consent, and a covering letter which will include an explanation of your involvement in the recruiting process. I have attached copies of these documents for your information.
- I will provide reply-paid envelopes.
- I will require your organisation to create or access a list of up to 50 people who have visited a qualified social worker in your organisation during the past 12 months. These people must be at least 18 years of age.
- I will also require envelopes to be addressed and mailed to potential participants.
- Clients are requested to contact me directly by phone or email if they are interested in participating. I will require no further involvement from you once information packs have been mailed.
- A summary of the final report from this study will be sent to you if you are interested.

This process will ensure that the client's identity remains private unless they wish to contact me. It is important for me to also let you know that I will also request that the client **does not** reveal the identity of the social worker that they worked with. I understand that your involvement in this process is likely to cost a considerable amount of time. If there is anything else that you can think of that I can do to make this easier for you do not hesitate to let me know. While I would be very appreciative of your support you are under no obligation to be involved.



If you are interested in supporting this study and assisting me with recruitment or have any further questions you can contact me on 0400 260 667 or email [jhay@utas.edu.au](mailto:jhay@utas.edu.au).

Kind regards

Jenny Hay  
PhD Candidate (School of Sociology and Social Work, University of Tasmania).

## Appendix 6: Letter of Invitation to Social Work Clients

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Date

Dear

You will be receiving this letter either because you have made contact with me after seeing a flyer about my research **or** because you have seen a social worker within the last 12 months. If you are not responding to a flyer then this letter has been sent on my behalf by the agency in which you visited the social worker. The agency has not given me your name or details and your identity will remain anonymous unless you choose to contact me.

I am a PhD student with the University of Tasmania in Launceston and am conducting this study in partial fulfilment of my PhD degree. This research is being completed under the supervision of Dr Sonya Stanford, lecturer in the School of Social Work at the University of Tasmania. I am interested in speaking with you about the topic of care and social workers.

I have enclosed an information sheet and consent form for you to read. I feel it is important that you know what will be involved if you decide to participate. If you are interested in participating I will ask that you sign the consent form with me before we begin the interview.

If you are interested in participating you can contact me on 0448 384822 or email [jhay@utas.edu.au](mailto:jhay@utas.edu.au). Thank you for taking the time to read this information.

Kind regards

Jenny Hay

PhD Candidate (School of Sociology and Social Work, University of Tasmania).

## Appendix 7: Information Sheet for Social Work Clients

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### **Title of project**

Exploring the relevance of an ethic of care in contemporary social work practice:  
Social workers' and clients' perspectives.

### **Who is involved in this study?**

My name is Jenny Hay. I am a social worker and I am completing my post graduate studies in Social Work as a PhD student through the University of Tasmania. I have chosen this area of research because of my interest in the idea of care in social work practice. My research is being completed under the supervision of the Chief Investigator, Dr Sonya Stanford, lecturer in the School of Social Work at the University of Tasmania.

### **Why is this research being done?**

While care is a taken for granted part of social work practice, it is not something which is talked about a lot in the profession. I am interested in speaking to both social workers and people who visit social workers to gain an understanding of how important the idea of care is to the people I speak to and how it is shown in social work interactions. I am conducting this research so that the social work profession can also gain this understanding and so that social workers can meet the needs of the clients we work with.

### **Are there any benefits for you?**

This is an opportunity to have a voice and share your experiences of working with a social worker. It is also a chance to make a contribution to the field of social work. The results will provide further information and understanding of the role of care in social work practice and potentially contribute towards changes to the way in which social workers practice in the future.

**What does this research involve?**

If you would like to be involved in this research I will be asking you to participate in an interview with me of around 1½ hours duration. The location and time of the interview can be arranged to suit us both. The sorts of questions I ask you will be about what the idea of care means to you, whether it is important that a social worker cares and how have social workers shown/not shown care towards you. You will also be encouraged to bring up any views or issues that you feel are relevant to this topic. You are not obliged to answer any questions that you do not feel comfortable with. With your permission, your interview will be audio recorded. This recording will be typed up and a copy will be sent to you to check if there is anything you would like to add, change or remove before I use it in the research. I will also provide you with a summary of the final report when the research is completed.

**As a token of my appreciation of your participation and to assist in covering any costs participation may incur you be offered a Coles/Myer voucher to the value of \$50.00.**

**Who is eligible to participate in this research?**

The only requirements for participation are that you are at least 18 years of age and have visited with a qualified professional social worker within Tasmania during the past year. Not all counsellors are social workers. You can be sure that the person you saw is a social worker if the role their workplace is titled 'social worker' or if they have the letters AASW or BSW after their name. If you are unsure you may like to check with the organisation which you visited.

**How to express interest in participating**

You can call me on my mobile no 0400 260667 or email me at [jhay@utas.edu.au](mailto:jhay@utas.edu.au) to discuss the research further or clarify any concerns. If I do not answer my phone please feel free to leave a message and I will call you back as soon as possible. If I do answer immediately I am also happy to call you back so as to save you telephone costs. Your contact with me will be treated respectfully and with confidentiality at all times.

**How is my identity protected?**

I am aware that it is important that your identity is protected. In order to minimise the chances that you will be identified I will transcribe all interviews in the privacy of my office at the Launceston University Campus. Only the chief investigator and supervisor of this research will have access to the recordings and all transcripts and recordings will be kept in a locked filing cabinet or on a password protected computer. All data will be deleted or shredded and destroyed after five years. Your anonymity will also be maintained by giving your interview and transcript a false name which you can choose if you wish to do so. Your consent form will also be kept separately from your transcript. Also to prevent anyone from being able to identify you from the completed thesis or future articles you are invited to delete anything from the transcript that you believe may identify you.

**What happens if participation results in emotional distress?**

I do not expect that the interview will result in any significant emotional distress. However it is possible that talking about your experiences may bring up unpleasant memories which could be somewhat upsetting. You are not obliged to tell me what the issue was that brought you to the social worker unless you wish to. Also, if you feel uncomfortable, anxious or upset at any time during the interview, you are welcome to stop the interview and request that the recorder be turned off. You can then decide whether you just need a break, would like to change the topic, finish the interview or even withdraw from the research. As a counsellor I am confident that I can interview you in a sensitive and respectful manner where you feel supported and safe if you do feel any distress. If at any time after the interview you continue to feel anxious or upset you may access the following free support services.

**Lifeline telephone counselling****13 11 14****Anglicare****63 346060****What happens if I feel unwell or tired during the interview?**

If you are feeling unwell on the day of the interview please do not hesitate to contact me and schedule another time. If during the interview you begin to feel unwell or it

becomes too tiring we can take a break or discontinue the interview. All you need to do is let me know and we will discuss the options.

It is also important to understand that participation in this study is purely voluntary and you will not be judged or disadvantaged in any way if you decide not to participate or continue to participate.

### **Statement regarding approval**

Ethics approval was granted for this research (Reference No: H11854) from the Human Research Ethics Committee (Tasmania) Network on 6th July 2011.

### **Who else can I contact if you have any queries or concerns?**

If you have any concerns about this project or the way that it is being conducted you may contact Katherine Shaw, Acting Executive Officer of the Human Research Ethics Committee (Tasmania) Network on (03) 6226 2763 or via email [Katherine.Shaw@utas.edu.au](mailto:Katherine.Shaw@utas.edu.au). You are also welcome to discuss this project my supervisor and Chief Investigator, Dr Sonya Stanford. She is available on (03) 63 243720 or via email [Sonya.Stanford@utas.edu.au](mailto:Sonya.Stanford@utas.edu.au). For general queries or if you would like to contact me to participate, I am available via email [jhay@utas.edu.au](mailto:jhay@utas.edu.au) or on mobile number 0400 260667. A statement of informed consent will be made available to all potential participants.

Thank you for taking the time to read this information.

Kind regards

Jenny Hay  
PhD Candidate (School of Sociology and Social Work, University of Tasmania)

## Appendix 8: Consent Form for Social Work Clients

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### **“Exploring the Relevance of an Ethic of Care in Contemporary Social Work Practice: Social Workers’ and Clients’ Perspectives.”**

1. I have read and understood the “Information Sheet” for this project.
2. I understand that participation in this study will require being involved in an interview which will take approximately one and a half hours and that this interview will be recorded.
3. I understand that I will have the opportunity to review the transcript of the interview and may choose to change or delete any part of the interview at my discretion.
4. The nature and possible effects of this study have been explained to me.
5. I understand that the following risks are involved.
  - I could potentially be identified in the research.
  - I may feel some emotional discomfort when talking about practice situations.
  - I may find the interview process tiring.
6. I understand that a number of precautions have been taken to avoid these risks.
7. I understand that the research data will be securely stored on the University of Tasmania premises for at least five years, and then will be destroyed.
8. Any questions that I have asked have been answered to my satisfaction.
9. I agree that research data gathered from me for the study may be published provided that I cannot be identified as a participant.

10. I understand that the researchers will maintain my identity confidential and that any information I supply to the researcher(s) will be used only for the purposes of the research.
11. I agree to participation in this investigation and understand that I may withdraw my participation at any time without any effects, and if I so wish, may request that any data I have supplied to date be withdrawn from the research.
12. I understand that I am obligated to respect the privacy of the identities of the social workers and agencies that feature in my examples.

Name of Participant:

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Signature:

Date:

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**Statement by Investigator**

I have explained this project and the implications of participation in it to this volunteer and

I believe that the consent is informed and that he/she understands the implications of participation.

Name of Investigator:

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Signature of Investigator: \_\_\_\_\_

Date: \_\_\_\_\_

I would like to receive a copy of the results of the study

Yes

No



## Appendix 9: Interview Schedule for Social Workers

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**1** - What does the concept of care in relation to your practice mean to you?

**2** - Can you talk about your views on whether care is a part of your ethical framework in social work practice?

*Sub question* – How might this view impact on decisions you make when facing ethical dilemmas in your practice?

**3** - How does your idea of care fit within the organisation in which you work?

*Sub question* – Do you experience any conflict between your views on care and those of the organisation you work in and if so can you explain how these conflicts are experienced and managed by you?

**4** - Can you describe a practice situation where you have demonstrated your idea of care?

**5** - In what ways do you believe care is beneficial in your practice if at all?

**6** - Can you think of any potential problems with incorporating care into your ethical framework and if so what are the issues?

**7** - How important do you believe it is to consider the unique situation of each client?

*Sub question* – If this is important how do you do this?

**8** - What personal qualities and skills do you believe clients value most in a social worker? How important do you believe these are in practice?

**9** - Is there anything at all that you would like to add to what we have talked about today?

## Appendix 10: Interview Schedule for Social Work Clients

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- 1 - Can you describe in your own words what 'care' or 'caring' means to you?
- 2 - As you know this study is about social workers and the care they demonstrate or don't demonstrate when they work with people. How important do you think it is for a social worker to "care".

*Sub question* – Is it important at all or is it more important for example that they are competent and knowledgeable and efficient about getting what you need?

- 3 - When working with a social worker what would they need to do to show that they care about you? What sorts of things would indicate that they did not care?
- 4 - What personal qualities do you think are most important in a social worker?
- 5 - Can you describe an interaction that you have had with a social worker where you felt that they showed care? Has there been a time when you have felt that a social worker did not care?

*Sub questions* – What did this mean to you?  
What happened? Can you talk about this in your own words?  
What impact did the care have on you and what was the value of this for you?

- 6 - Do you believe that your social worker really understood how you felt and what you needed?

*Sub questions* – How was this understanding shown or not shown?  
Did you feel as if you were really listened to?

- 7 - Is there anything at all that you would like to add to what we have talked about today?

## Appendix 11: Letter to Participants Accompanying Interview Transcript

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“Exploring the Relevance of an Ethic of Care in Contemporary Social Work Practice: Social Workers’ and Clients’ Perspectives”

Date

Dear

I would like to thank you once again for your participation in my research. It was a pleasure to meet with you.

As discussed, I have enclosed a copy of the transcript of our interview. I have typed up the interview exactly as it was recorded which is why it reads as a conversation rather than a typical document. Please do not be concerned about any ums, ahs or disjointed sentences as this is perfectly normal when we talk.

If there is anything that you would like to change, add or delete from this transcript please do not hesitate to contact me so that I can make the requested changes or meet with you again to discuss this. I can be contacted on 0448 384822 or by email

[jhay@utas.edu.au](mailto:jhay@utas.edu.au).

Kind regards

Jenny Hay

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